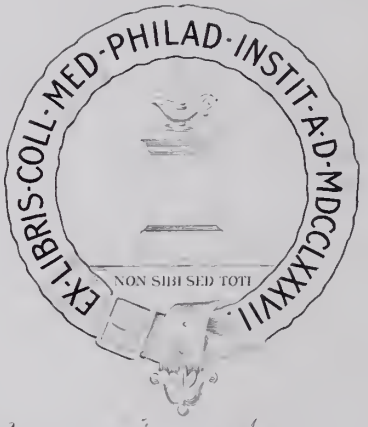
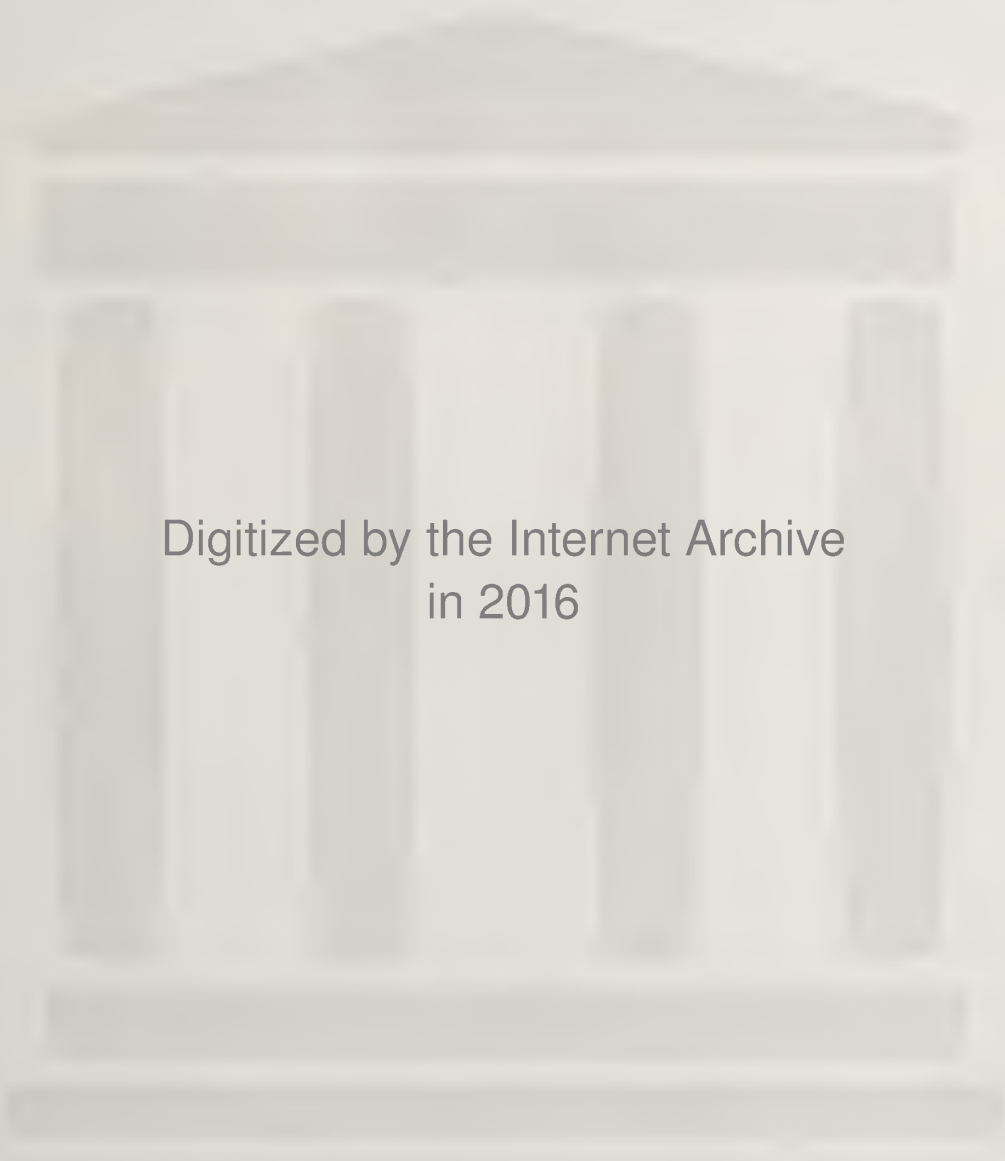


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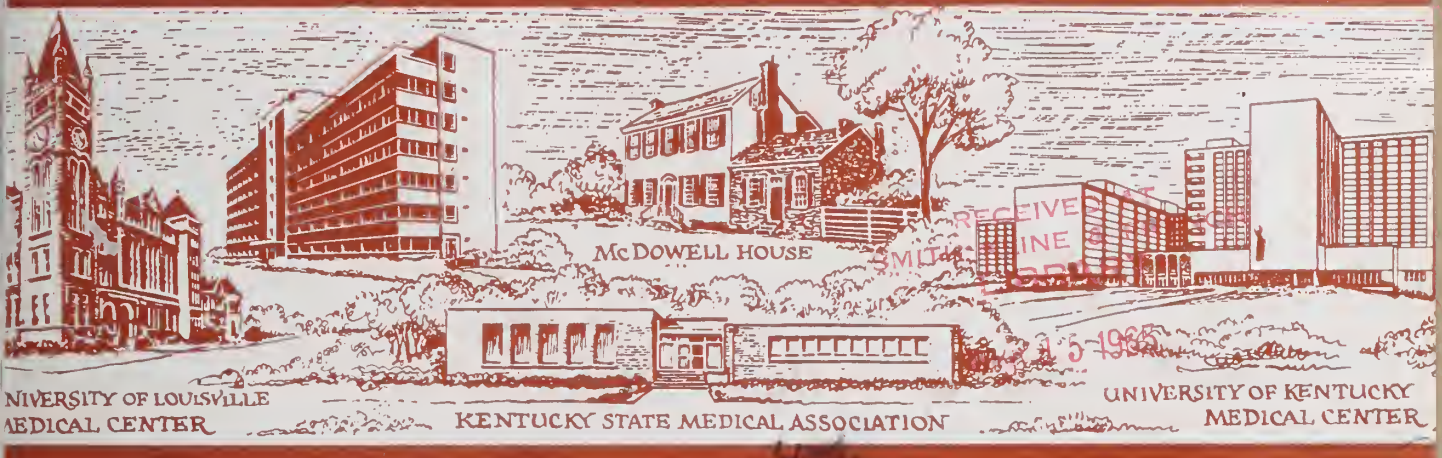

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THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION



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*Roseman, E.: *Neurology* **11**:912, 1961. 33664

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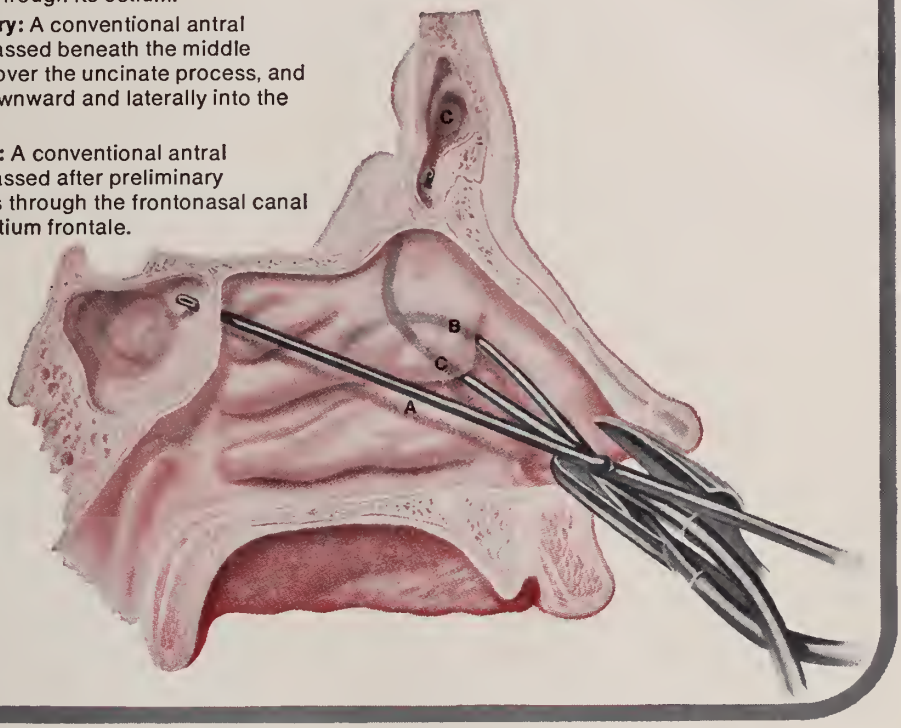
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A rhinologic approach to the sinuses
Sagittal anatomical section of nasal cavity showing approach for probing or irrigation by cannulas.

A—Sphenoid: A sphenoid cannula (under 13.5 cm.) passed around the middle and superior turbinates to the anterior wall of the sinus through its ostium.

B—Maxillary: A conventional antral cannula passed beneath the middle turbinate, over the uncinate process, and rotated downward and laterally into the ostium.

C—Frontal: A conventional antral cannula passed after preliminary maneuvers through the frontonasal canal into the ostium frontale.



In colds and sinusitis

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Available in plastic nasal sprays for adults (½%) and children (¼%), in solutions of ⅛, ¼ or 1 per cent.

*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

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MESSAGE FROM THE PRESIDENT



Plan Prepare Perform*

A NEW YEAR begins in medical service for the Woman's Auxiliary. In previous years the women have striven to aid their physician husbands in the furthering of all facets of medical education, appreciation, and endeavor in order to fulfill the entire aim of medical service. In recent years it has been more apparent and important for all of us to do all that we can in the furtherance of modern medical aims. Because of the ever-increasing dissemination of knowledge among our populace it has become necessary for the medical profession to use every means at its command not only to maintain its position of leadership, as in the past, but to further enhance that position in the future.

Foremost in the minds of our Auxiliary members for the coming year are the objectives of promotion and friendly relations for mutual understanding among physicians' families; participation in any endeavor on the request of the Kentucky Medical Association; coordination and advise concerning the activities of constituent auxiliaries; and extension of the aims and service of the medical profession to all organizations which look to the advancement of health and health education.

The extension of the scope of Auxiliary work represents a necessary change with the times, but the change, per se, has no virtue; only when the change gives more meaningful direction to a group and to the individual does it advance a society of free men.

Each Auxiliary member is ready, willing and able to assist the Medical Association in all of its undertakings in order to bring about the culmination of this golden age of medicine.

"You are the fellow who has to decide
Whether you'll do it or toss it aside
You are the fellow who makes up your mind
Whether you'll lead or linger behind—
Whether you'll try for the gold that's afar
Or be contented to stay where you are
Take it or leave it, there's something to do;
Just think it over, it's all up to YOU."

MRS. J. JACK MARTIN, PRESIDENT
WOMAN'S AUXLIARY TO THE KMA

This is the first of a series of guest articles written at the request of KMA President Delmas M. Clardy, M.D., by the president of the Woman's Auxiliary to KMA and the three KMA vice-presidents.

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PUBLIC HEALTH PAGE

Hospital and Medicial Facilities Survey and Construction Act*

(Kentucky's Hill-Burton Program)

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health, Commonwealth of Kentucky

IN 1946 the Hill-Burton Program was launched. By June 30, 1964, this Program—one of the most important health acts ever enacted in the United States—had completed and/or had under construction in Kentucky over 230 projects. Total costs of these projects exceeds $150,000,000 with Federal grant-in-aid funds to the applicants amounting to over $66,000,000 and state grants totaling over $2,000,000. Included in these projects are new hospitals, additions to, and remodeling of existing hospitals (general, mental, tuberculosis, chronic disease), schools of nursing, public health centers, nursing homes, diagnostic and treatment centers, and rehabilitation centers.

The Hill-Burton Construction Program has reached almost every county in the state and has also made very significant contributions to the establishment and expansion of the medical centers in Louisville and Lexington.

A retrospective evaluation of the accomplishments of the Hill-Burton Program would indicate great advances, both quantitative and qualitative. During the past eighteen years the bed population ratio in Kentucky has increased from 2.3 suitable general, acute hospital beds per thousand population to the present ratio of 3.2 per thousand. This gain was recorded despite a population increase of approximately fifteen percent during the same period, which required a tremendous amount of new construction simply to counterbalance the population increase.

The major qualitative gain that should be mentioned are: (1) development of minimum standards for health facilities construction which have resulted in improving the design, functional relationship, and overall efficiency of health facilities, (2) requirements for a continuous inventory and positive planning for the orderly development of hospital and medical facilities expansion in the State, (3) better geographic distribution of health facilities, especially in rural areas where physicians and board qualified specialists are so vitually needed, and (4) the upgrading of licensure requirements due to Hill-Burton regulations regarding operation and maintenance of health facilities constructed under the Program.

Despite the impressive gains already made in improving and expanding Kentucky's health facilities much work is confronting us in the future. If we are to meet these future needs, a major in emphasis is necessary in our health facilities construction program. This shift in emphasis at a national level is very apparent in the recently enacted 1964 amendments to the Hill-Burton Act. The most far-reaching change in the Program is the establishment of a new grant program for modernization or replacement of public and nonprofit hospitals and other health facilities, giving special consideration to those lcoated in the more densely populated areas where the greatest need exists. This represents a major shift of emphasis, in that the Hill-Burton Program from its inception has given priority to the construction of additional facilities and beds, particularly in the rural and financially disadvantaged areas.

The new legislation also provides for a single category of funds to support the construction of long-term care facilities (previous appropriations were divided between chronic disease hospitals and nursing homes, which created problems in planning). In addition to combining the categorical appropriations, the amount appropriated was almost doubled. This is particularly significant in that the number of aged in our population is rapidly increasing and the gap between existing and needed facilities will become even wider unless money is made available to finance construction of long-term care facilities.

Thirdly, the 1964 amendment provided for special areawide planning grants to public or nonprofit agencies to conduct planning studies. Proper planning helps relate each health facility in the community or metropolitan area to the total complex of health services and to other community planning. Planning is essential if we are to avoid the extravagance of unnecessary hospitals, or hospitals built in the wrong places, hospitals too small to be effective, and unnecessary duplication of immensly expensive equipment. It is essential not only in terms of capital costs but of operating costs; while traditionally coming from different sources, they are now more closely related.

The physicians' constant goal to elevate medical science coupled with the construction of modern medical facilities under the Hill-Burton Program has certainly made a truism of Michael M. Davis's statement, "within living memory an age-old institution has been transformed from a hotel for sick poor into a medical center for everyone."

This article was prepared by Paul A. Hackney, Director Hospital and Medical Facilities Program Kentucky State Health Department Frankfort, Kentucky



Of 507 patients with confirmed ear, nose and throat infections... 465 or 91.7% were treated successfully with Signemycin®

Note:
Adams,* whose 50 patients included 20 with ENT infections, stated that Signemycin "was particularly valuable in infections that did not respond to other antimicrobial agents, and in patients to whom penicillin could not be given." All his cases responded within five days; in most patients, all signs of infection disappeared in three days.

*Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957.

Condition	No. of Patients	No. Responded To Signemycin
Otitis media	90	86
Pharyngitis and laryngitis	162	148
Sinusitis	68	55
Tonsillitis and peritonsillitis	163	153
Various	24	23
Totals	507	465 (91.7%)

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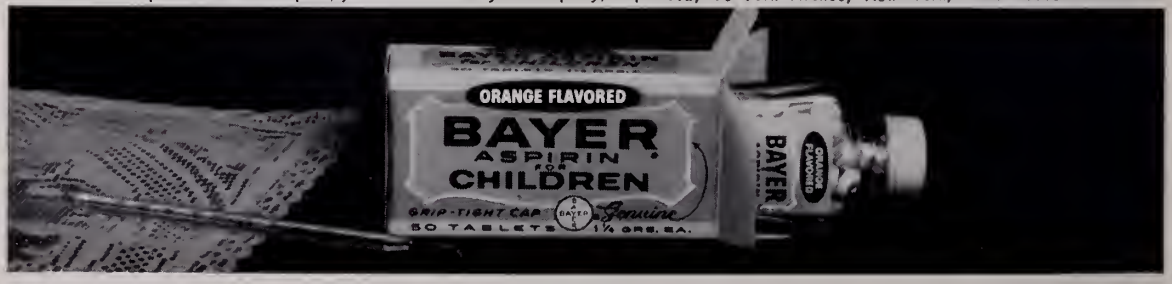


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Of 1,028 patients with confirmed respiratory infections... 954 or 92.8% were treated successfully with Signemycin®

Note:
Hammerl* selected his patients for treatment with Signemycin on the basis of demonstrated bacteriological resistance to other antibiotics or failure of previous therapy. Of 100 patients with various respiratory tract infections, 95 responded to Signemycin. Pathogens isolated included staphylococci and *Diplococcus pneumoniae*.

*Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958.

Condition	No. of Patients	No. Responded To Signemycin
Abscess, pulmonary	17	16
Bronchiectasis	19	13
Bronchitis	286	267
Bronchopneumonia	192	179
Empyema	12	11
Pneumonia, lobar	150	146
Pneumonia, other febrile	160	150
Various infected pneumopathies	192	172
Totals	1,028	954 (92.8%)

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Q. Can members reduce their Blue Shield protection to lower their dues?

A. *This is not recommended; however, if they have Schedule D Blue Shield, they have the right to reduce to Schedule C; or they can drop back from Preferred to Standard Blue Shield or change to Schedule C. Blue Shield is a voluntary program and members have the choice of various levels of protection.*

Q. Do you have any reason to believe that doctors raise their fees when the patient has a higher allowance Blue Shield Plan?

A. *Some doctors may do so; however, most physicians realize that members pay more for higher Blue Shield allowances so that they can meet their responsibility to the doctor. Prepayment for doctors' services will die if members are penalized (charged more) for services than patients with no prepaid protection.*

Q. Do you expect that home and office calls will be added to Blue Shield benefits?

A. *Blue Shield can offer such protection now if the public is willing to pay for it; however, these benefits are less costly if paid for out of pocket and not through prepayment.*

Q. Does Blue Shield ever cancel a group?

A. *Yes, if they fail to pay or if they give notice that they are terminating Blue Shield to enroll in other coverage.*

Q. Can Blue Shield rates be raised at any time?

A. *Yes, if made necessary by high utilization, except on groups which have rates guaranteed for one year; on such groups rates can be increased only at the start of a new contract year.*

Q. Why doesn't Kentucky Blue Shield permit non-group members to pay by the month as some other Blue Shield plans do?

A. *Because of the increased administrative and mailing costs.*

Q. Have all Blue Shield rates been raised recently?

A. *No. Rates have not been increased on Direct members and many groups of 50 or more subscribers. Rates have been increased on all groups under 50 subscribers because the costs of services was higher than dues being paid, and on those groups of 50 or more with utilization in excess of 100% of dues paid.*



Of 1,021 children with various confirmed infections... 950 or 93.0% were treated successfully with Signemycin®

Note:
The effectiveness of Signemycin was demonstrated by Chattas and his co-workers* who administered Signemycin to 30 children with serious staphylococcal infections resistant to commonly used antibiotics. Only one failed to respond. In each case the use of this drug was indicated by antibiogram. Those children treated with a nonselected antibiotic—for comparative purposes—took three times longer to recover.

Chattas, A. et al.: Antibiot. Med. 7:300, May, 1960.

Condition	No. of Patients	No. Responded To Signemycin
Eye, ear, nose, throat infections	368	343
Respiratory infections	369	346
Gastrointestinal infections	42	30
Skin and soft-tissue infections	38	37
Deep-seated or generalized infections	47	44
Various conditions	157	150
Totals	1,021	950 (93.0%)

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

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Brief Summary and Bibliography follow.

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Bone and joint infections	71	64
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Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
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IN THE BOOKS

PREVENTIVE MEDICINE IN WORD WAR II, VOL. VII—COMMUNIABLE DISEASES: edited by John Boyd Coates, Col., M.C., U.S.A., and Ebbe Curtis Hoff, M.D.; published by the Office of the Surgeon General, Department of the Army, 1964; 370 pages; price, $4.25.

This publication is the seventh of a clinical series encompassing the official history of the Medical Department of the United States Army in World War II. There are, in addition, three volumes describing the administrative and operational events during this era.

This volume summarizes the experiences with arthropod borne diseases other than malaria (separate volume) and tularemia. Each chapter deals with an infectious disease encountered in an arena unfamiliar at that time not only to the troops in general but also to the medical officers and military entomologists. In general, each chapter opens with a historical summary followed by a description of the disease and the procedures instituted for prevention and control.

The entities described include Encephalitis (A. B. Sabin), Bartonellosis (M. Hertig), Dengue (O. R. McCoy and A. B. Sabin, Filariasis (J. C. Swartzwelder), Leishmaniasis (H. E. Meleney), Plague (K. F. Meyer and O. R. McCoy), Relapsing fever (H. S. Fuller), Sandfly fever (M. Hertig and A. B. Sabin), Epidemic and Murine typhus fevers (Bayne-Jones), Scrub Typhus (C. B. Philip), Rocky Mountain Spotted Fever (G. M. Kohls) and, Yellow Fever (Bayne-Jones).

The chapters on dengue, plague, and the typhus fevers were particularly appearling to this reviewer. Unquestionably, through accelerated and emphasized research efforts, a great amount of information was gained relative to these agents. For example, multiple immunologic types of dengue were found, the long persistence of immunity to homologous types, the interference phenomenon with yellow fever, and many other basic properties of the virus were recognized. The plague and typhus fevers stories should be of interest to everyone.

This book is well-written and, although the most recent developments in each field are not covered, it does provide a summary of events during a period when we were forced to deal with these "foreign" agents.

It also serves in part to answer a common question of medical students, i.e., "We will never see this disease, why study it?"

CHARLES W. FISHEL, PH.D.

ATLAS OF GENERAL SURGERY: by Joseph R. Wilder, M.D.; published by the C. V. Mosby Co., St. Louis, 1964; 317 pages; price, $23.50.

This single volume atlas reviews briefly one hundred operative procedures which over a period of years have become fairly well standardized. Sections on lymphography, angiography and vascular surgery represent the important additions to this second edition. The brief and superficial coverage of so important a subject as pre-operative care begs for its omission as the first chapter.

Textual comment is kept to a minimum. A brief but valuable paragraph outlining the possible pitfalls and complications precedes the description of each operation. Lucid black and white illustrations accompany the descriptive text. Excessive lines and shading often used to give detail and perspective are omitted. This lends to the clarity and rapid comprehension of the maneuvers involved in the operative procedures.

It is unfortunate that the chapter on venous cutdown procedures emphasizes the use of the saphenous vein. The extremely high incidence of serious complications has caused most surgeons to avoid indwelling cannulae in the lower extremities. Likewise, it is thought that the placing of such cannulae over moving joints is poor technique. The basilic vein in the antebrachium and the cephalic vein in the brachium lend themselves well to venesection and cannulation.

The author's comment in Chapter 61 that "a cecostomy should accompany all low anterior resections" is not universally accepted. Many surgeons have found decompression with only a nasogastric tube or gastrostomy necessary following anterior resections of the colon. Others have weighed the effectiveness of a cecostomy against its possible complications and strongly question its place as a decompressive procedure.

The greatest value of the book is for the surgical intern and resident who, embarking upon a career in surgery, need a guide for the standard procedures. To the experienced surgeon who is more intimately involved with detail in technique, this volume will be disappointing.

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1. Griffith, R. S., and Black, H. R.: Current Ther. Res., *6*:253, 1964.

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Modern Trends in the Treatment of Gas-Gangrene†

George Benton Sanders, M.D.*

Louisville, Ky.

Although a startling reduction in the mortality of gas-gangrene has been achieved by Hyperbaric Oxygen Drenching, it is suggested that surgery is still the primary treatment and all other methods adjuvant.

NOT TOO long ago, many extremity battle wounds were considered, and often proved to be "mortal", if their situation made it impossible for the surgeon to amputate safely. Of several factors contributing to the fatal outcome, gas-gangrene was one of the most important. The radical treatment of amputation lingers on today as the curative effort of last resort in cases of gas-gangrene involving an extremity.

When the clinical, bacteriological, and pathological features of Clostridial infection were revealed by William Welch in 1900, possibilities for radical surgical treatment of gas-gangrene short of amputation, became apparent. From 1900 to 1936, these have consisted mainly of extensive debridement, wide surgical exposure of tissue planes, various forms of surgical drainage, wound irrigations with antiseptic and oxygen-liberating solutions, and supportive treatment; with amputation reserved as the last, but often necessary effort.

The advent of each new physical, chemical, and immunological modality useful in the treatment of anaerobic infections, has consistently, but temporarily, reduced the vigor of the surgical attack on gas-gangrene, often with disastrous results.

In rough order, these new useful, but not curative, modalities are:

(1) The x-ray, discovered by Konrad Rontgen in 1895.
X-ray therapy for gas-gangrene was enthusiastically tried in the 1930's with disappointing results. It is now rarely employed.

(2) Chemotherapeutic agents, introduced in 1937, of equivocal value, and now superseded in their role by:

(3) Antibiotics:
In order of preference:
(1) Penicillin
(2) Chloromycetin
(3) Tetracycline
These are extremely valuable as bacteriostatics, preventing in large part such characteristic clostridial activities as exotoxin production. By themselves, they are not curative.

(4) Anti-gas-gangrene serum introduced in 1918.
At first weak and non-effective, today's anti-gas-gangrene preparations are considered to be potent, safe, and by most authorities, invaluable. It is felt that in some way they potentiate the antibiotics.

Effect on mortality figures of the introduction of these new, and undeniably valuable

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agents has been strangely disappointing. Before 1935, for example, the mortality of gas-gangrene complicating appendiceal operations was approximately 41%. From 1935 to 1955, a period which saw the introduction and widespread use of valuable agents such as antisera and antibiotics, and during which time surgical skills and technic can be said to have made enormous advances, the mortality rose to a forbidding 81%. The reasons for this are not susceptible to statistical proof, but it is submitted that the emasculation of the surgical attack on gas-gangrene by the hope of cure by non-surgical methods, was probably the chief cause. (Tables 1 and 2)

Table I
POST-APPENDECTOMY GAS-GANGRENE OF ABDOMINAL WALL — 1900-1950
(After Capiello)

Total Cases	25
Mortality	
1900-1935 inclusive (Surgical Rx in 7 of 10)	43%
1936-1950 inclusive (Surgical Rx in 1 of 15) Antisera, Antibiotics, etc.	81%

Table II
ABDOMINAL WALL GAS-GANGRENE
1900-1963

Mortality Entire Series (115 cases)	61.6
Mortality Surgical Treatment (Plus Antibiotics, etc.)	41.6
Mortality Non-Surgical Treatment (Antibiotics, Antitoxin)	81.6

From Sanders, G.B.; Gas-Gangrene of the Abdominal Wall (7).

MacLennan, from a vast personal experience with war-wound gas-gangrene and from information gained in the experimental laboratory, has stated unequivocally that all ancillary methods of treatment, no matter how potent, are futile if any portion of involved muscle or tissue is allowed to remain. In other words, treatment fails if surgery is omitted or debridement has been faltering or if amputation, when indicated, has been withheld.

For example; early in World War II (1940-1942), the mortality of gas-gangrene was 50%. Tempted by the great advances in surgical technic and physiology during the preceding 20 years, surgeons were neglecting fundamental principles of wound care learned at great cost in the First World War. One of the most important of these was the principle of debridement and delayed closure of extremity wounds, especially those involving bone.

As these lessons were painfully relearned, the mortality of gas-gangrene dropped to 30% in 1943, and then to 22% in 1944-45. During this span of five years, the factor subject to the most change was the steadily greater acceptance and utilization of prompt wound excision, debridement, and lastly, amputation, for dirty, compound, war-wounds.

It is interesting to observe that each time inexperienced surgeons were brought into a front-line sector, the incidence and the mortality of gas-gangrene in that sector rose significantly.

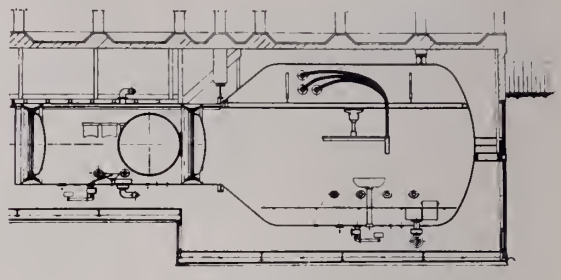


Figure 1a.

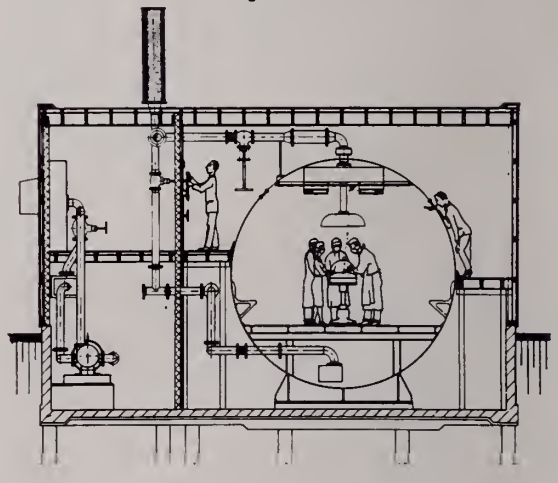


Figure 1b.

Figure 1. Diagrams of Hyperbaric Chamber in use at the surgical clinic of Professor Dr. I. Boerema, Wilhelmina Gasthuis Amsterdam, Holland. Reproduced with the permission of Professor Boerema, and the C. V. Mosby Company, publishers of Surgery.

(a) Diagram of Hyperbaric Chamber, longitudinal view.

(b) Diagram of Hyperbaric Chamber, cross section view.

Since 1955, a number of cases of gas-gangrene have been treated in Holland and in Glasgow, by means of Hyperbaric Oxygen Drenching. In this technic, the patient is placed in a hyperbaric chamber under two or three atmospheres pressure, and breathes 100% oxygen for periods of 60 to 90 minutes, two or three times daily. Careful decompression routines are necessary. The essence of the technic is the "drenching" of tissues with oxygen, by supersaturating plasma and lymph with oxygen in physical solution some ten to fifteen times

over normal levels. This creates an environment unfavorable for Clostridial growth and activity, including exotoxin production.

Greatly reduced mortality figures are claimed for this method of treatment. Boerema and Brummelkamp in Holland, have stated that the results are so startling that they omit antisera, withhold all surgical procedures until the Clostridial sepsis is controlled, and use antibiotics only as prophylaxis against secondary infection by non-Clostridial organisms.

It would seem that this constitutes a return to the philosophy of 1935-55, and should in due time, be greeted by a similar rise in mortality figures, if what we have learned by experience, and from the painstaking work of MacLennan and others, is valid. Indeed, Smith and Sillars of Glasgow have recently reported a case of gas-gangrene which actually *developed* while under prophylactic treatment with Hyperbaric Oxygen Drenching. Extremity amputation and return to the Hyperbaric Chamber was necessary for cure.

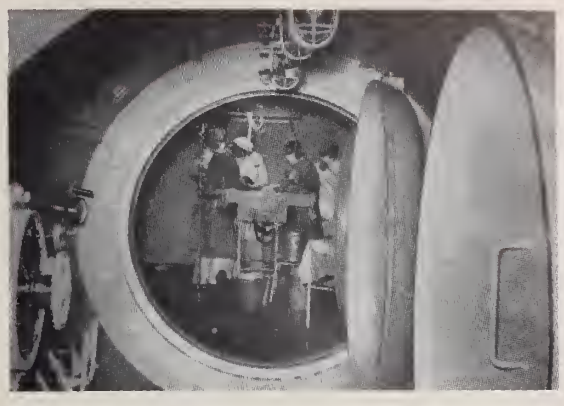


Figure II. Surgical debridement under way in the Hyperbaric Chamber.

Discussion

In evaluating statistical studies on case series of gas-gangrene, it is most important to differentiate cases of clostridial cellulitis, which has a low mortality and which responds to simple, less drastic measures, from those of true gas-gangrene or clostridial myonecrosis, which has a high mortality and requires heroic treatment. Most authorities consider that the clostridial-myonecrosis-toxin-interaction provides the lethal mechanism in gas-gangrene. If muscle is not involved, this is absent and the resulting cellulitis and bacteremia can and does respond to antibiotics, antisera, and/or simple surgical measures. An example is clostridial pneumocholecystitis, which often can be treated successfully in this manner without resorting to surgery. If such an entity is operated upon inadvertently, or in ignorance, the cholecystectomy incision provides access to the abdominal musculature, and the stage is set for the development of true gas-gangrene, a fulminating and highly fatal situation.

Like antisera and antibiotics which are distributed via the blood and lymph circulations, oxygen-supersaturated plasma and lymph cannot reach tissues bereft of circulation, and again like antisera and antibiotics, can be expected to fail in true gas-gangrene cases where muscle necrosis is prominent. The observations of MacLennan have already been alluded to in this connection.

This is not to deny Hyperbaric Oxygen Drenching its rightful place as the most valuable ancillary treatment for gas-gangrene yet devised, but it does strongly suggest that, as in the past, the primacy of surgical therapy will not be displaced.

Conclusions

(1) Hyperbaric Oxygen Drenching (H.O.D.) gives promise of being the most valuable ancillary treatment yet devised for gas-gangrene.

(2) As such, H.O.D. takes its place alongside other, older, extremely valuable ancillary agents such as antibiotics, and anti-gas-gangrene antitoxin.

(3) Prompt and proper surgical debridement and drainage still remains the mainstay of successful treatment for gas-gangrene. Without it, all ancillary methods of treatment can be expected to fail consistently.

(4) The modern concept of ideal treatment for a case of gas-gangrene would therefore consist of:

(a) Prompt, adequate, surgical debridement, wide exposure of involved tissue planes, radical resection of infected muscle; with amputation reserved as a last resort.

(b) Hyperbaric Oxygen Drenching begun as soon as possible.
Surgical debridement carried out in the Hyperbaric Chamber, if possible.

(c) Intensive antibiotic administration:
1. Penicillin, 4-6 million units daily supplemented by,
2. Chloramphenicol, gm. 5.0 daily, or

3. A suitable Tetracycline in equivalent doses—orally or parenterally.

(d) Intravenous administration of a polyvalent anti-gas-gangrene antiserum, containing 18,000 International Units each of C1. perfringens, and C1. novyi, and 9,000 International Units of C1. septicum antitoxin as an initial dose, repeated as indicated, up to a total dose of 150,000 International Units.

(e) Supportive treatment with blood transfusions, corticoids, etc.

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Menstrual Disorders of the Teenager

John W. Greene, Jr., M.D.*, and John L. Duhring, M.D.**

Lexington, Ky.

Menstrual problems of the second decade are discussed. It is emphasized that the patient have an accurate detailed history, particularly of her growth and development, as well as a thorough physical examination. The necessary laboratory work is delineated and suggestions for therapy given.

MENSTRUAL problems of teenagers may be divided into the following categories: amenorrhea, (primary or secondary), menorrhagia, metrorrhagia, and dysmenorrhea. In evaluation of these problems the physician must remember that the menarche is but one event during the growth and development of the individual. It is mandatory that the patient have an accurate detailed history as well as a thorough physical examination. In many instances the pelvic examination is difficult and not performed due to the patient's natural reluctance, but it is essential. If vaginal examination is not possible, then recto-abdominal examination may substitute.

Amenorrhea

The physician is frequently consulted by an anxious mother awaiting her daughter's first menstrual period. The age of the menarche may normally vary from the age of nine to as late as sixteen. In attempting to answer the mother's inquiry as to the predicted onset of menstruation there are several historic factors which will prognosticate the onset of the menses. There is a period of maximum body growth immdiately preceding the first menstrual period. This growth is virtually completed in from one to three years after the menarche. This is due to the fact that estrogens produced at the menarche cause epiphyseal closure and thereby inhibit linear growth. Thus, girls who have an early menarche are usually shorter in stature as adults than those individuals in which menarche appears later.[1]

One of the first signs of puberty is the development of breast buds. These are first noted as a small firm area about the areola. A small amount of pubic hair appears approximately three years prior to the first menstrual period. About two years before the first menstrual period there is increased breast growth in that the former small nodule becomes lobulated with enlargement of the breast and areola. There is growth of the pelvis including deposition of fat which gives the distinct female contour to the hips. The breast changes are an index of estrogenic activity since the mammary tissue is extremely sensitive to estrogenic stimulation. About one year before the first menstrual period there is a definite increase in pigmentation of the areola, and an increase in public hair concurrent with the development of axillary hair. Six months prior to the onset of menstruation the axillary hair is well established and a mucoid leukorrhea can be noted. The leukorrhea is due to activity of the endocervical glands and is certain evidence that menstruation will occur within six months.

When menstruation has not occurred by the age of seventeen, investigation is indicated. As was stated previously, a thorough pelvic examination is an integral part of the evaluation. A history of episodic crampy abdominal pain should immediately bring to mind the possibility of imperforate hymen. When on pelvic examination no anatomical defects can be demonstrated which would obstruct flow, other factors must be considered: the hypothalamic-pituitary ovarian axis, the thyroid, the adrenal, chronic diseases, psychogenic disorders, and severe nutritional imbalances.

Evaluation of the hypothalamic-pituitary function may be obtained by assays of pituitary gonadotrophin. In primary hypofunction the urinary levels of follicle stimulating hormone,

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and luteotrophic hormone will be low, whereas in primary ovarian failure the excretion of these hormones will be high. Patients with pituitary deficiency often are obese and they tend to curtail their intake of essential foods which further aggravates the pituitary problem. These patients are best treated by means of a balanced diet with a high protein intake, and addition of supplemental vitamins. If hypothyroidism is also a factor, thyroid hormone may advantageously be given. Since human gonadotrophin replacement therapy is not commercially available, the only hormonal therapy practical is cyclic estrogen and progesterone therapy. A period of six months of such cyclic therapy should be given when pituitary deficiency is established. Rarely a space taking lesion of the pituitary or hypothalamic area will be the etiology of amenorrhea, and it is the amenorrhea that brings the patient to the physician. Examination of the eye grounds and skull x-rays should make this diagnosis.

A rare entity has been described wherein the uterus is unresponsive to normal amounts of ovarian hormones. In these instances exogenous, cyclic administration of estrogen and progesterone may evoke vaginal bleeding. Many women have been diagnosed as having an infantile uterus because on physical examination it was thought to be small, but one must be very careful in making this diagnosis because of its extreme rarity.

Estimation of estrogen production and end organ effect can be obtained by taking a vaginal smear or measuring vaginal pH. Intermediate or cornified epithelial cells in the vaginal smear and a neutral or acid pH of the vagina provide a reliable index of estrogenic activity. If the age of seventeen has been reached without menstruation and these estrogenic effects are noted, the administration of progestational compounds may be used as a further diagnostic test of the endometrial status. If bleeding occurs after the administration of progesterone, one is assured that there is adequate estrogen present and the end organ is capable of functioning. When bleeding occurs under these circumstances, the prognosis for the establishment of normal menstruation is good. Treatment with on oral progestin from day 20 to day 25 of the simulated cycle should be carried out for at least three months.

Thyroid problems during puberty are common. The increased demands made on the thyroid by a growing body often cause relative degrees of hypothyroidism. Symptoms and signs suggestive of hypo-function of the thyroid gland include mental and/or physical lethargy, constipation, sensitivity to infection, slow pulse rate, low blood pressure, a cold skin, and retarded bone age. If the appropriate diagnostic tests have confirmed hypothyroidism, replacement therapy will with rare exception initiate menstruation.

In the evaluation of the patient, other possible causes of amenorrhea such as chronic disease, psychogenic disorders, or severe dietary deficiencies should be delineated and corrected when present.

The development of a regular menstrual cycle and the associated secondary sexual characteristics show great normal variations from one individual to another. It should be forcefully emphasized that to hasten or meddle with normal growth and development by early and improper endocrine therapy is totally unwarranted.

In the experience of many, laboratory determinations of excretion of estrogen and progesterone have yielded little if any valuable information; for, in the minute amounts found, the wide variations of normal are so common that the information obtained is meager. It is therefore emphasized that the signs of physical growth and development coupled with vaginal smear and pH are far more important as guide posts to the etiology and management of amenorrhea than expensive laboratory tests. Extensive laboratory investigation should be reserved for the complex problems not responding to the above outline of diagnosis and management.

Secondary Amenorrhea

For two to three years following the menarche episodes of amenorrhea are commonly encountered. One must think of pregnancy. Anemia, hypothyroidism, tuberculosis, and diabetes can arise at this time and can be the etiologic factor. Psychic factors are often important. The pressures of social activities, school, and occupational problems can create a tremendous tension in our teenagers and are often responsible for the development of adolescent menstrual irregularities. These disturbances are generally self limiting and treatment includes institution of a program emphasizing good nutrition, adequate rest, proper exercise,

and promotion of good mental hygiene. A simple explanation of the problem to the youngster is often all that is necessary. However, failure of the menstrual cycle to return after six months is indication to pursue the endocrinc studies and therapy as suggested for primary amenorrhea.

Menometrorrhagia

Immediate post menarchal menstrual periods tend to be anovulatory and may remain so for several months or years. This lack of ovulation and a progestational phase of the endometrium is undoubtedly responsible for many of the menstrual irregularities of adolescence. The diagnosis of pubertal dysfunctional uterine bleeding can be assumed in young girls with prolonged vaginal bleeding and in most instances without the aid of endometrial curettage or biopsy. A bimanual rectal-abdominal examination is usually all the pelvic investigation necessary in the virgin with prolonged or irregular menstrual periods. However, one must always keep in mind the possibility of pregnancy or pelvic tumor.

Rare as they are in teenagers, malignancies of the genital tract are accompanied by irregular vaginal or uterine bleeding. An endometrial polyp or submucous myoma also may rarely be an organic cause for abnormal uterine bleeding and may be missed at the time of diagnostic endometrial curettage. These conditions may become evident when other means of therapy are not curative.

One must always think of the possibility of the teenage girl acquiring certain sex steroids and taking them in an unsupervised fashion. In these instances, she may develop amenorrhea, metrorrhagia, or menorrhagia. Hypothyroidism and hyperthyroidism enter into the differential diagnosis of abnormal uterine bleeding. Either of these forms of thyroid disease may be accompanied by profuse, prolonged bleeding.

Menstrual excesses and prolongations in adolescent females may have their primary cause in a blood dyscrasia. For this reason a blood study must be performed on all young patients with prolonged uterine bleeding. However, do not assume that a slight abnormality of coagulation must be the etiologic factor, since even patients on heparin and bishydroxycoumarin may have perfectly normal menstrual cycles.

Occasionally the physician will be faced with severe menorrhagia in a youngster. Such patients can on occasion bleed so profusely that borderline shock occurs. It is not unusual to find that some of these youngsters have bled heavily for a period of a week or two. Objectives of treatment are to stop the bleeding, to restore the blood volume, and to improve the adolescent's general health. In order to obtain hemostasis, the patient is put in bed. Study of the peripheral blood is done, and the degree of secondary anemia established. A platelet count, clotting time, and observation of the clot retraction will exclude 99% of the blood dyscrasias. After this the blood volume and hematocrit are brought to normal by transfusion. It is interesting that although its etiology is not understood, the chronic anemia seems to prolong vaginal bleeding, and it is amazing how often the bleeding can be stopped upon adequate blood replacement. However, if such cessation is not forthcoming within hours, curettage is in order. Examination under anesthesia followed by dilatation and curettage is both diagnostic and therapeutic. This examination will rule out pelvic pathology such as neoplasms, extensive congenital erosions, and cervical or endometrial polyps. A dilatation and curettage will cure up to 80% of these young women. In a majority of cases the endometrium on currettage shows varying degrees of proliferation and hyperplasia indicating immature ovarian function. After this, attention must again be paid to the thyroid status, nutrition, and the consideration of cyclic therapy with estrogen and progesterone. Frequently administration of an oral progestin during the second half of the menstrual cycle will serve to regulate the flow until pituitary and ovarian balance is achieved. Occasionally repeated episodes of menorrhagia are encountered necessitating curettage, even to the point of five to six such procedures over a period of years. However, such is much better than hysterectomy or radiation of the ovary.[2]

Greenblatt and others have recommended the use of intravenous conjugated equine estrogen to control episodes of menorrhagia.[3] This is repeated in 12 to 24 hours followed by the administration of 1.25 mgs. by mouth four times a day. This is continued for ten days, followed by administration of an oral progestin for five days to produce a secretory endometrium. Withdrawal bleeding from a secretory endometrium will take place. This with subsequent normal flow is the "Medical D & C".

Dysmenorrhea

Pelvic organic lesions are only occasionally the cause of primary dysmenorrhea in the adolescent although this possibility should not be overlooked. Organic lesion such as cervical stenosis, retroverted uteri, pelvic inflammatory disease are rarely seen in a group of virginal girls. In the great majority of teenagers dysmenorrhea is a variation of a physiological process.

Dysmenorrhea seldom occurs at the onset of menstruation. It is associated with ovulation and the production of progesterone and usually occurs one to three years after the menarche. Psychic factors may be contributory, particularly in patients with associated anatomic nervous system disturbances which include nausea, vomiting, weakness, and syncope. These patients are indeed in the minority, but when the patient is presented to the physician with severe nausea, vomiting, and other gastrointestinal upsets at every menstrual period, they become a major problem. The tendency to over-emphasize the psyche and disregard other possible factors is not in the best interest of the patient. Often it is only necessary in these people to emphasize to them a few things. They are normal. They are functioning properly and the fear that they will not be able to have children is absolved. Many young girls only want to know that this problem is an exaggeration of a physiologic process.

In the management of dysmenorrhea simple measures should be used primarily. Participation in all regular activities and physical exercise should be encouraged without restriction. References to infantile-uteri or retroverted uterus are to be avoided. Analgesics without narcotics may be presented, it should be emphasized: without narcotics. If this should fail one can use progestins to suppress ovulation. This is done from the 5th to the 20th day of the cycle and will afford relief. If it does not, then one must think of organic lesions or severe psychic difficulties that may even necessitate psychiatric care. The administration of progestins for three to four months to these people will give comfortable periods. When the therapy is withdrawn, frequently painful menses do not recur immediately, but when they do, the girl knows that she can have relief again if she needs it. Although dilatation and curettage is rarely indicated in this young age group, they may be used to control dysmenorrhea. Presacral neurectomy is rarely indicated in the management of dysmenorrhea during adolescence.

In summary, although the great majority of these problems can be self limiting and not serious, it is important to take adequate histories, to examine, and to educate these young ladies.

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Stapedoplasty—Autogenous or Prosthetic

Arthur L. Juers, M.D.
Louisville, Ky.

Stapedectomy offers the patient with clinical otosclerosis (stapes ankylosis) at least a 90% chance of restoring useful hearing. Functional continuity is reestablished by either an autogenous stapedoplasty reconstruction or insertion of a wire prosthesis.

SEVERAL aspects of stapes surgery remain to be solved. One of the major questions which has not been answered is to what extent should an attempt be made to reconstruct a stapedoplasty using only the patient's own tissuse? Having used such a technique in selected cases about four years ago, I thought that it would be worthwhile to evaluate this experience in contrast to a more recently used prosthesis type of technique.

Since Rosen[1] reintroduced stapes surgery 12 years ago, there has been a gradual evolution from simple mobilization to total stapedectomy. In the past few years, however, there has been a slight diminution in the initial enthusiam concerning routine complete stapedectomy.

Pathology

A brief consideration of pathological variations in otosclerosis is a necessary prerequisite to the intelligent discussion of surgical technique.

Otosclerosis is defined as a local osteodystrophy which causes hearing impairment chiefly by progressive fixation of the stapes. Cochlear involvement is associated with the conduction lesion in some cases. Pure sensorineural loss due to otosclerosis is rather uncommon.

Predisposition to otosclerosis is largely genetically determined. This is evidenced by the fact that identical twins tend to have similar lesions. Acceleration of progression of the lesion is influenced by both intrinsic and environmental factors of stress. One factor which particularly concerns us in stapes surgery is the otosclerosis accelerating effect of surgical trauma. Obviously, this may defeat the general objective of our surgery.

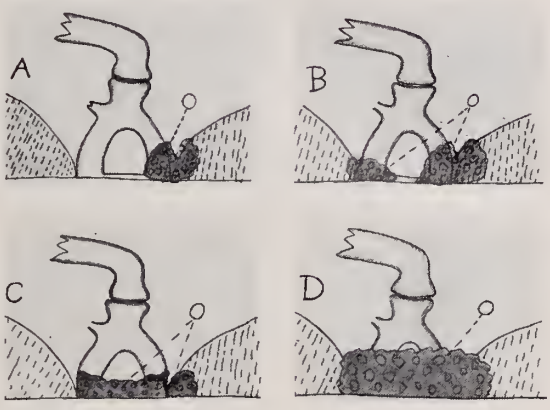


Figure 1. O—Otosclerotic bone in each sketch shown as shaded area. A. — Lesion limited to anterior footplate. B. — Both anterior and posterior lesions. C. — Extensive footplate involvement but footplate margin still apparent. D. — Complete obliteration of fossa ovalis.

Variations of the otosclerosis lesion causing fixation of the stapes are shown in Figure 1. While the sketches show only four general types of lesions, there is actually a continuity of involvement varying from minimal anterior to total obliteration of the fossa ovalis. A recent report on the histological study of footplates removed at surgery indicates that lesions limited to the anterior end of the footplate are rather uncommon. The most common finding was multiple lesions throughout the footplate even when gross inspection indicated only anterior involvement.[2]

Selection of Cases

Otosclerosis manifests itself by a slowly progressive hearing loss of the conduction type, usually becoming apparent to the patient between the age of 18 - 30. Fortunately it is infrequent below the age of 15. Progression to complete stapes fixation may occur in several years or may cover a period of 20 - 25 years. Complete stapes fixation in the presence of good cochlear function results in approximately 40 - 45% hearing loss which reduces hearing

†*Presented at the September 26 meeting of the Kentucky EEN&T Society meeting during the 1963 KMA Annual Meeting in Lexington.*

**Clinical associate professor of otorhinolaryngology at the University of Louisville School of Medicine.*

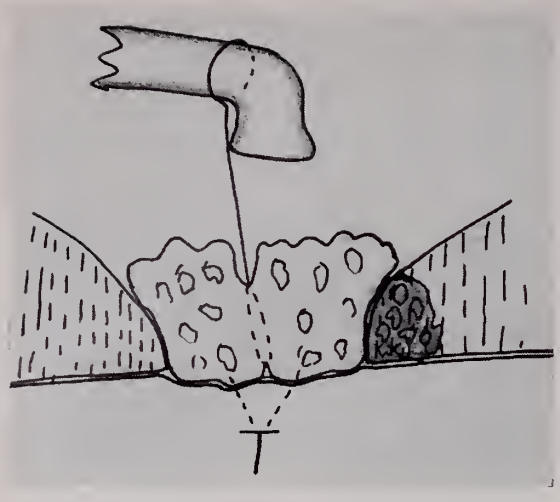


Figure 2. Entire stapes has been removed and replaced with a tissue plug (T) and wire prosthesis. Fine stainless steel wire connects incus with tissue plug in oval window.

for ordinary speech to about one foot. Audiometrically a patient with total stapes fixation has a 50 decibel loss by air conduction with normal or near normal hearing by bone conduction. The difference between the air conduction and bone conduction threshold is called the air-bone gap.

A simple test for determining the status of the conduction mechanism is the Rinne test with the 512 fork. If the patient hears the fork better by bone than by air, the hearing loss is of the conduction type. If the acuity is better by air than by bone, the conduction mechanism has adequate function and any hearing loss present is of the sensorineural type.

In general a patient with a history indicating otosclerosis and normal tympanic membranes is considered suitable for stapes surgery if the air-bone gap is 25 db. or more. Patients with changes in the tympanic membrane may be considered for surgery if the Eustachian tube has adequate function.

Patients below the age of 18 usually have very active, vascular lesions and, in general, should not be considered for stapes surgery at the present time. The problem of stapes surgery for congenital conduction lesions will not be considered in this discussion.

There is no precise upper age limit for stapes surgery if the bone conduction threshold indicates that a useful level of hearing may be obtained and speech tests indicate that discrimination is adequate.

Surgery

The general objective of stapedoplasty is to create some type of mobile structure to replace the fixed stapes. The criteria of good surgery can be listed as follows:

1. Closure of the air-bone gap.
2. Minimal or no cochlear damage.
 a. No drop in bone conduction acuity.
 b. Preservation of hearing for high frequencies.
 c. No loss of speech discrimination.
3. Permanence.
4. Must not create a hazard to life—i.e. labyrinthitis secondary to otitis media years after surgery.

The general experience of otological surgeons has been that secondary operations increase the hazard to cochlear function considerably. Consequently the earlier concept that, if hearing regression occurred after an initial simple mobilization a secondary more extensive operation could be performed, is no longer considered sound judgment. Consequently, the first operation should be adequate enough to be the last for each ear.

A satisfactory stapedectomy technique was first described by Shea.[3] He removed the entire stapes and sealed the oval window with a small vein graft. A short piece of polyethelene tube was placed between the incus and the vein graft to restore functional continuity of the ossicular chain. However, the technic required frequent use of a burr and as a result there was a disturbing incidence of cochlear damage. He has now largely abandoned this technique and is now using a small Teflon® piston which extends through a small opening in the center of the footplate. Whether such an opening through an otosclerotic footplate will consistently and permanently stay patent remains to be seen.

Kos[4] and Schuknecht[5] developed a tissue plug—wire prosthesis to replace the stapes. This is shown in Figure 2. Kos has used a piece of vein and Schuknecht a piece of fat from the ear lobe.

House[6] has used compressed Gelfoam® to seal the oval window with a wire prosthesis between the incus and the gelfoam. A thin membrane of tissue grows into the Gelfoam matrix in a period of several days.

Hough[7] has evolved a partial stapedectomy technique in which he removes the anterior

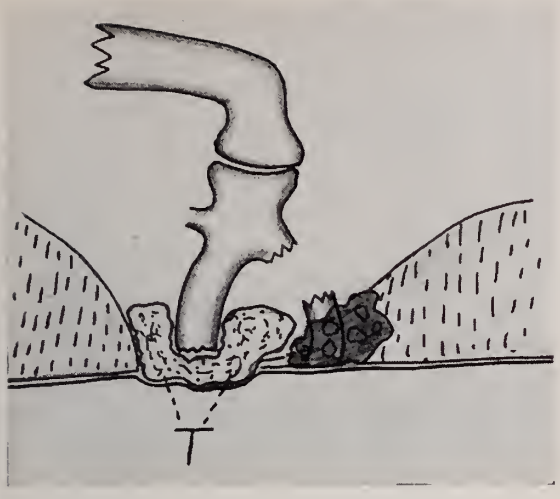


Figure 3. Autogenous stapedoplasty. Posterior half of footplate is removed. A tissue graft (perichondrium) is placed beneath posterior crus in opening into inner ear. A portion of the anterior crus is removed.

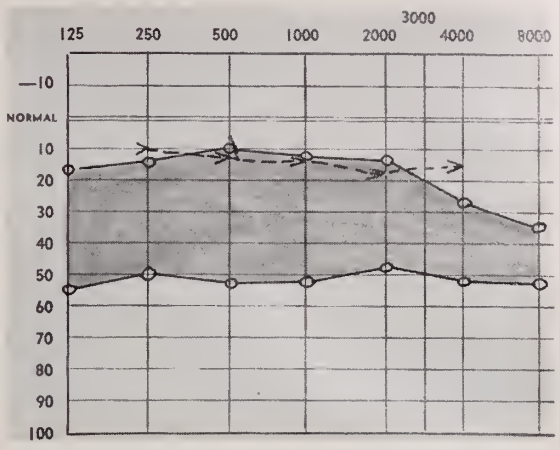


Figure 4. Hearing improvement in 30 cases of autogenous stapedoplasty. Average preoperative level at bottom of shaded area and postoperative at the top. Preoperative bone conduction level indicated by dotted line and arrows.

part of the stapes and then shifts the posterior part of the footplate forward.

An autogenous stapedoplasty was described by the author[8] about four years ago. This is shown in Figure 3. The technique is rather difficult but the functional results have been excellent and maintained to date. Unfortunately, this technique cannot be carried out in about half of the cases because of anatomical and pathological reasons. However, in these latter cases, a prosthesis technique can then be used.

Results

In 30 selected cases in which the autogenous stapedoplasty just described was used about four years ago, the air-bone gap was completely closed in all cases and this improvement has been maintained to date. The shaded area in Figure 4 shows the improvement obtained.

Three years ago I started to do routinely a total stapedectomy with tissue plug-wire prosthesis replacement. 151 consecutive cases operated on by this technique over a period of 18 months have been reviewed.

In 138 of these cases the stapes footplate could be removed without the use of a burr. In all but one of these cases a satisfactory air-bone gap closure was obtained. In nine cases the otosclerotic lesion had obliterated the fossa ovalis as in Figure 1-D and it was elected to open the oval window with a burr. In these nine cases, a satisfactory hearing improvement was obtained in five. In four other cases on inspecting the stapes area, the otosclerotic lesion was found to be extremely vascular and in such situations no attempt should be made to open the oval window as the risk of cochlear damage is too great. Also in such cases the regrowth of bone will promptly reobliterate the oval window with a loss of any hearing improvement which may have been obtained at surgery.

A satisfactory hearing improvement was obtained in 142 of this group of 151 cases in which a total stapedectomy—prosthesis technique was used. The hearing has been maintained to date. The chief difference between these cases and the autogenous stapedoplasty cases is that the total stapedectomy cases have slightly more injury to the higher frequencies as indicated in Figure 5.

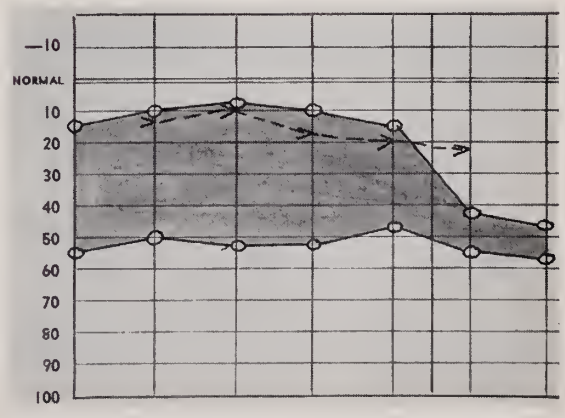


Figure 5. Hearing improvement in 30 cases of stapedectomy with fat graft wire prosthesis replacement in which a burr was not used.

Severe early postoperative cochlear function depression occurred in two cases in which the burr was used. However, over a period of three months the hearing in both cases returned to a useful level though there was a slight permanent loss of speech discrimination.

Discussion

Though the observations and evidence to date are favorable, the long range tolerance to plastic prosthesis in the middle ear is not known. Many patients operated on have another 40-50 years of life expectancy. Stainless steel has been shown to be well tolerated in other areas over many years.

A critical point for a prosthesis is its junction with the incus. A too-tight grip can lead to erosion of the incus. With meticulous surgical technique, however, this is apparently an uncommon occurence.

Another aspect of prosthesis technique is whether to use a tissue-plug or gelfoam to seal the oval window after partial or total footplate removal. The general consensus of opinion now seems to be that a tissue plug creates slightly more initial labyrinth reaction immediately after surgery but affords better protection against suppurative labyrinthitis in the event of otitis media months or years after surgery. I have had two tissue plug prosthesis cases develop otitis media a year or two after surgery and there was no evidence of extension into the labyrinth.

The piston technique is new and remains to be evaluated. Initial results are good with minimal evidence of cochlear damage. However, there are occasional regressions of hearing improvement due to otosclerotic bone growing beneath the piston opening.

On the basis of my own experience and reports from others, I plan at the present time to proceed as follows in stapes surgery:

1. Do an autogenous type of stapedoplasty with a posterior partial stapedectomy when anatomy and pathology permit.
2. If a satisfactory autogenous procedure cannot be performed, then total stapedectomy with fat graft-wire prosthesis will be carried out.
3. Burr out of obliterated lesions will be considered only if there is no gross vascularity.
4. If the oval window becomes obliterated with bony regrowth after primary stapedectomy, no further oval window surgery will be considered.
5. Patients under 18 years of age who apparently have progressive clinical otosclerosis are advised to defer surgery for the present.
6. Patients who are found on clinical examination to be suitable for stapes surgery will be advised that they have a 90% chance of obtaining a satisfactory long range improvement in hearing and that there is about once chance in 200 that there may be a severe permanent cochlear depression following surgery.

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A Report of Endrin Poisoning

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Jacqueline A. Noonan, M.D.,***
and Peter P. Bosomworth, M.D.****

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An unusual case of poisoning with a chlorinated hydrocarbon insecticide commonly used as a tobacco spray is reported. Survival was attributed to the method of control of convulsions and the management of ventilation.

ENDRIN is a versatile chlorinated hydrocarbon insecticide commonly used as a tobacco spray. A case of Endrin intoxication treated in this hospital prompted us to review the literature in relation to the management of human poisoning with this insecticide.

Case Report

A two-year-old white female was admitted to this hospital four hours after having ingested a teaspoon of Endrin concentrate, a Chlordane-like product used to kill tobacco worms. Immediately following ingestion, the child screamed because her mouth burned. The father washed out her mouth and applied cold cream to that area. She resumed playing but one-half hour later began to convulse. One hour following ingestion her stomach was lavaged at another hospital. Convulsions could not be controlled with the administration of large doses of phenobarbital, pentobarbital, and chloral hydrate. Following this therapy her ventilation was seriously depressed and she became increasingly cyanotic. She was transferred to the University of Kentucky Medical Center for further treatment.

The patient's past history and systemic review were non-contributory.

On physical examination the patient was a well-developed, well-nourished, obtunded child having myoclonic convulsions every 15 to 20 seconds. The pupils contracted during the convulsions. The blood pressure was 100/70 mm. The pulse was regular and greater than 200 per minute, and the respirations were shallow at 40 per minute. There were fine vesicular rales in both fields and rhonchi were transmitted throughout the upper tracheo-bronchial tree. The abdomen was distended and hyperresonant; the liver, kidney, and spleen were not palpable and the urinary bladder was distended.

Admission laboratory work revealed a hemoglobin of 13.5 grams per cent, hematocrit 43 volume per cent, WBC 7800/mm.^{3} with 14 per cent polys, 53 per cent stabs, 31 per cent lymphs and 2 monos. Urinalysis was negative. The serum electrolytes were within normal limits. A chest x-ray shortly after admission was interpreted as aspiration pneumonitis or pneumonitis secondary to the irritative action of the Endrin.

inserted into the trachesa. The patient was pla-

On admission a Cole endotracheal tube was inserted into the trachea. The patient was placed on a Bennett assistor-controller ventilator. The stomach was decompressed. Since rather large doses of barbiturates had failed to control the convulsions, an intravenous infusion of succinylcholine was given at the rate of 1/2 to 1 mg. per minute over the next 24 hours. This infusion rate paralyzed the child, stopped the convulsions, and permitted easy control of ventilation with humidified 40 per cent oxygen using the Bennett assistor. A urinary catheter was inserted. The pneumonitis was treated with tetracycline 75 mg. b.i.d. intravenously and hydrocortisone 75 mg. intravenously q.8.h. and the patient was maintained on intravenous fluids. The endotracheal tube was changed every eight hours.

At the end of 24 hours the patient no longer needed succinylcholine for the control of convulsions. The mechanical ventilation was discontinued 28 hours after admission. Eight hours after the termination of the intermittent positive pressure therapy, respirations were adequate as measured by the Wright respirometer and the endotracheal tube was removed. The

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patient responded to stimuli with purposeful movements although she was not fully awake. She was placed in a croupette immediately after extubation in order to minimize the occurrence of post-intubation croup. She tolerated oral fluids on the fourth hospital day and was removed from the croupette at that time. The remainder of the hospital course was marked with gradual improvement in the level of consciousness of the patient and in clearing of the chest X-ray.

The patient was seen 20 days post-poisoning by the Psychiatry Department for psychometric examination and electroencephalography. These examinations failed to reveal any evidence of neurologic damage either local or generalized. She has continued to exhibit normal growth and development over the past year since the occurrence of the poisoning.

Discussion

A review of the literature reveals three reports of Endrin intoxication in humans. The first is a case report of a one-year-old boy whose room had been sprayed with Endrin and who subsequently developed acute intoxication and survived with residual neurologic damage attributed to hypoxia.[1] The second is a case report of a two and one-half-year-old child who died on the sixth day post-intoxication with decerebrate rigidity.[1] The third report involved 59 persons who developed food poisoning from eating bread rolls made of Endrin-contaminated flour.[2] The dose of the drug taken was not known; however, Endrin was found to be present in the flour to the extent of 5500 parts per million. Endrin was recovered from some parts of the bread consumed to the extent of 150 parts per million. There were no deaths in this report and recovery in all cases was felt to be complete.[2]

Endrin is soluble in aromatic hydrocarbons and ketones, sparingly soluble in alcohol and paraffin hydrocarbons, and insoluble in water. As marketed for formulation purposes, it is available as a granular product containing 90 to 95 per cent Endrin and has a faint medicinal smell. The material is subsequently dissolved in an aromatic hydrocarbon and sold on the commercial market as a liquid. Endrin has the highest acute toxicity of the chlorinated hydrocarbon insecticides.[3]

The exact mechanism of action of chlorinated hydrocarbons in man and insects is not known. They are systemic poisons to insects, fish, and mammals. Intoxication may occur by absorption through the intact skin, by ingestion, or by inhalation. Regardless of the route of administration, when effective doses are administered the physiologic reaction appears to be the same.

The median lethal dose varies from 15 mg./kg. to 6,000 mg./kg. of any of these materials when administered to rats.[4] Loss of appetite, salivation, and central nervous system stimulation characterized by hyper-irritability to stimuli, tremors, convulsions, and ultimately death results. If death is immediate, no histopathologic changes are found in the liver or kidneys.[4] The onset of acute poisoning from Endrin intoxication may begin anywhere from 20 minutes to several hours after ingestion, depending upon the dose. The first symptoms may be dizziness, weakness in the legs, abdominal discomfort, nausea, vomiting, and apprehension followed by disturbances in equilibrium and mental confusion. The most serious development is the occurrence of convulsions with associated hypoxia.

Summary

A case report is presented of a two-year-old child who survived after ingestion of undiluted Endrin base without apparent neurologic damage. Following an unsatisfactory response to barbiturate therapy for control of convulsions, she received an intravenous infusion of a muscle relaxant and intermittent positive pressure breathing with a mechanical ventilator.

This case substantiates the report of animal experimentation which indicates that there is no specific neurologic damage resulting primarily from the Endrin intoxication but that the deaths in both animal and clinical reports are probably due to hypoxia secondary to the convulsions. The survival of this child is directly related to the maintenance of respiration with a mechanical device and to the control of her convulsions with the use of a muscle relaxant.

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Relationship Between the Private Practitioner and the Public Health Physician †

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Theories involving ancient public health laws and the private practice of medicine are discussed. It is pointed out that some of these customs survive even in modern times.

IT is curious that the subject of this paper might have been discussed about the campfires of paleolithic man. This matter is certainly not of only recent interest. The cave men of ten and twelve thousand years ago probably discussed the merits of their private practitioner and the wisdom of certain taboos that had been passed by the priests and the governing body. One can well imagine the ancient medicine man inveighing against generally accepted taboos and screaming about the effects they would have upon his private patients. Thus early in history we come upon a clear cut separation between the man who is dealing with disease in the individual and the man who is devoting his energies to preventing disease in the entire population.

Ancient History

As man moved into primitive cities such as Jericho, around Carmel, near Karnac in Egypt, and in ancient Sumeria, the increasing concentration of populations made this separation and specialization within the general field of medicine mandatory. The ancient Sumerians in the region of the Tigris and Euphrates rivers, had extensive laws relating to water and the pollution of water. One can read of wars fought over water rights and over the pollution of water. Thus 6000 years ago man was already concerned with the field of preventive medicine as well as the treatment of disease in the individual. The laws of Hammurabi contained rules governing the private practice of medicine and also established rules of public health. The code of Hammurabi provided that the physician who was responsible for the loss of a patients hand would lose his own hand. Certainly such stringent laws are well relegated to history and do not recommend themselves to present adoption. In this same field of the regulation of medicine for the common good, one finds the Greeks, as usual, had an answer to it.

The early Greeks, who treated individuals at the temples at Kos, Epidaurus and even in Athens, had a simple solution to determining just which patients they would accept within the temple for treatment. The distance of the temple from any usual center of population was almost always very great so, by the time the patient arrived at the temple grounds, the physician could be fairly certain that the disease was not of an acute or drastic nature. Secondly, the temples were usually approached by a long flight of steps. An individual who managed to get up to the top of the steps had to be in fairly good physical condition. Thus by these two devices of choosing patients, the early Greek physicians were almost always assured that the patient would not die within the temple but would, in all probability, be capable of responding to or tolerating their ministrations. A corollary to this device for almost guaranteeing successful treatment was the fact that the patient had to travel long distances and only a person of adequate financial background could do so. Thus these physicians were assured patients able to survive treatment and able to pay for it. The magnificence of the temples at Epidaurus and Kos testifies to the success of these financial arrangements of private practice during the Golden Age.

The pattern of the private practice of medicine was well established by 1000 B.C. So was the pattern of public health. It has been said that Moses was probably the first public health officer. The ancient Mosaic code brings into prominence the many sanitary, or Kosher laws that were existant at the time of Moses and

†*Presented at the September 26 meeting of the Kentucky Society of Pathologists held at Lexington in conjunction with the 1963 KMA Annual Meeting.*

probably had existed for eons before Moses appeared. Though we ordinarily think of the Kosher laws as religious laws, they were in truth public health laws and directed at the prevention of disease.

The prohibitions regarding the eating of pork were well founded in observations that swine harbor diseases such as trichinosis and other diseases transmissible to man. What is more logical than a prohibition against a potential source of illness for man? The early Jews also recognized in a very practical way, the transmissibility of disease. For example, the burying sites for the dead were never visited because the places might be a source of infection. When the Romans came to Israel and Herod the Great built the famous city of Tiberias on the Sea of Galilee, he inadvertently chose the site of an old Jewish burying ground. It is interesting to note that from the day of the establishment of Tiberias it was always used by the Romans but no Jew ever entered the city because the land had been used for burying purposes. This may seem a bit obscure until one recognizes that the bodies placed in the ground might be infected with a variety of contagious diseases and thus be a source of epidemics.

The Kosher custom of the separation of milk and meat becomes understandable when one thinks of the paucity of water and the absolute lack of refrigeration in the environment of the ancient Jew. Certainly a dish that had been used for milk would be a good culture medium for bacteria. Imagine then placing meat in such a dish and leaving it for a few hours without refrigeration. This would provide one with a stew that would certainly be disabling, if not lethal. Are these not examples of public health practice? These early public health officers also inquired into the contamination of water supply. The Arabs still follow many of these ancient customs and laws which were designed to protect the public water supplies.

Curiously enough, one of these Islamic laws now insures the spread of schistosomiasis. According to the religious law, defecation should occur near running water and immediately after defecation the anus and perianal region should be washed with water. Unfortunately this law provides the means by which the schistosome issuing from the alimentary tract of the infected person can return to the water environment and thus complete a cycle within the snail and be available for further development. This constitutes one of the major problems of public health in Egypt today and one of the problems of Nasser, dictator of Egypt, will be to repeal this ancient public health law.

Some of the most startling of public health laws were formulated and practiced by the ancient Spartans. Five hundred years before Christ these Spartans were devoting themselves to improving their race. They encouraged physical fitness programs among their youth and made physical fitness not only a matter of custom but a matter of law. This included rigidly prescribed exercise, diet and periods of training. The Spartans went even beyond this and into the field of eugenics. They selected certain youths to be fathers and certain females to be mothers. This improvement of the breed, as one might refer to it, was carried even further when an attempt was made to have all infants destroyed if they were deformed in any way. Any infant who showed any malformation or weakness was promptly taken out, thrown over a cliff and thus destroyed so that the defect might not be transmitted to future generations. By the time Christ was born Western man had already separated in his mind the two fields of curative and preventive medicine and one cannot but be impressed by the tremendous amount of public health law and public health practice that was existent 2000 years ago.

From the time of Christ on, progress in public health continued. The Romans borrowed from the Isle of Crete the idea of a bath within the home and also public baths. This necessitated plumbing of a high order. At the ancient city of Pompeii, one can see miles and miles of lead pipe used to conduct water throughout the city. In this same town one can see food shops with marble counters surrounding the great vats in which food was contained. These small sandwich shops of 2000 years ago, with their easily cleaned marble tops and the available water coming in lead pipes, showed evidence of the interest in food sanitation even in ancient Pompeii.

The Roman public health officials recognized the inherent dangers of malaria and there were prohibitions about living in swampy areas. The Roman engineers devised means of draining the swampy areas and thus could be called sanitary engineers. One can still see in Rome, vast aquaducts, some of which are still being used after 2000 years. By means of these aquaducts, fresh, pure water was brought from the moun-

tains twenty and thirty miles away. In this regard it is interesting to note that by the year 100 A.D. the seventeen aquaducts leading into Rome brought in more water to the population of approximately 500,000 people than is being brought into modern Rome with a population of over two million. As a matter of fact, the ancient Romans used five times as much water per person as the present day Romans. Certainly, without this clean water supply, Rome would have had many more epidemics than it did and the greatness of Rome can be in a large part contributed to these early public health officials.

Quarantine was a recognized device for handling epidemics for thousands of years. Even in the Bib'e one sees the word "unclean", which implies isolation of a possible carrier of disease. By the year 1400 this became a matter of law and the quarantine on incoming ships to the ports in Italy gives rise to our modern word quarantine.

One has a strange feeling as he reviews these stories and realizes that here are basic devices to prevent the transmission of disease and yet, so far as we know, none of these ancient peoples had any concept of bacteriology. Is it not curious that public health practice was so sophisticated when the practice of currative medicine remained so primitive and empirical?

Modern History

With the advent of the microscope and the knowledge of infectious disease, public health was able to re-evaluate its prescriptions and eliminate many of the nonessential elements. But the basic elements of public health have persisted and in many ways the techniques have remained the same. Following the development of the germ theory, giants in public health practice arose to bring the benefits of this new knowledge to all people. Here in Kentucky we are especially proud of men such as J. N. McCormack, M.D., and his son, Arthur McCormack, M.D., and their great successor, Phillip Blackerby, M.D., Doctor J. N. McCormack was the first health officer of the State of Kentucky. He left private practice and entered the field of public health and by his genius, spread knowledge of the germ theory throughout the State of Kentucky, bringing the benefits of this new knowledge to every Kentuckian. He formulated and had laws passed in the field of public health and today these laws are models of constructive public health legislation. He developed a public health team consisting of nurses, sanitarians, lawyers, laboratory workers and record keepers. Thus Doctor McCormack set the patten for modern public health practice; (1) Investigation, (2) discovery of fact, (3) dissemination of knowledge, (4) application and (5) enforcement.

Doctor Arthur McCormack and Doctor Blackerby got new help for public health from volunteer organizations. The first of these was the Rockefeller Foundation with its monumental studies in the field of hookworm in the Appalachian Mountains. In Doctor McCormack and Doctor Blackerby the Rockefeller Foundation found men who were trained and capable and the close team work between the public health physician and the Rockfeller Foundation eventuated in the establishment of the Kentucky sanitary privy, a public health sanitation program and a mass treatment effort. The result was almost total elimination of hookworm among the mountain people. Along with this came the studies of Goldberger into the causes of pellegra and almost at the same time there came studies in the field of trachoma and the beginnings of the elimination of these dread diseases. Typhoid and tuberculosis also came under fire. The public health nurse came into the field with her abilities in caring for the sick and educating the well and man's lot on this earth became an easier one and the prevention of diseases advanced.

Today the public health physician has moved into the field that I like to refer to as "Administrative Medicine." His concerns are with treatment of disease in the mass of population and in the prevention of disease in the mass of population. His background, his philosophy and his techniques in this highly specialized field have, therefore, had to vary quite widely from those of his brother, the private practitioner. The private practitioner must concern himself with being knowledgeable and competent in the treatment of disease in the individual. If he achieves this goal he is successful and a good private practitioner. As a contrast, the public health physician must not only be knowledgeable about many diseases, he must also be a capable administrator, an educator, a legislator, a law enforcement official, a politician and a man of vision for the future, for he must always be a planner of future progress; a man

(Continued on Page 66)

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Peripheral Neuropathy Due to Nitrofurantoin

F. Norman Vickers, M.D.*

THE reported toxic reactions to nitrofurantoin (Furadantin®) include skin rash, jaundice, hemolytic anemia of the Primaquine sensitivity type, and pulmonary infiltration. Polyneuropathy has been noted with nitrofurantoin as well as with other nitrofuran drugs.

Approximately 26 cases of polyneuropathy due to nitrofurantoin have been reported in the world literature. We have recently observed a case of severe polyneuropathy associated with nitrofurantoin therapy with complete recovery.

C. W., L.G.H. #10266. A 37-year-old Negro female was admitted to the Louisville General Hospital on 5/1/62 because of ascites and adema of two months duration.

She had consumed approximately 12 bottles of beer daily and an unknown amount of distilled spirits for many years. Approximately two months before admission she noted anorexia and morning vomiting. However, she was able to continue her customary intake of alcohol. Two weeks before admission she first became somewhat lethargic. There was a marked increase in the size of her abdomen and dependent edema was noted.

Two weeks before admission her urine became somewhat darker. She had not, however, noted jaundice.

She denied previous illness; she underwent four normal pregnancies. There was no family history of tuberculosis, diabetes mellitus or alcoholism. There was no documented history of urinary tract infection, although for several weeks she had urinary frequency and nocturia. She denied dysuria or hematuria. Menses were absent for the previous eight months.

Physical examination: The patient's weight was 133 pounds, blood pressure 120/80, and pulse 100. She was moderately jaundiced with obvious ascites. Numerous spider angiomata were noted over the chest. The tongue was beefy red. There was no Kaiser-Fleisher ring. The chest was clear to percussion and auscultation. The heart was not enlarged and no murmurs were heard. Shifting dullness and fluid wave were present. The liver was balloted 3 centimeters below the right costal margin; no distinct nodularity was felt. There was no splenomegaly or costovertebral angle tenderness. There was no weakness or tenderness of the extremities. Position and vibratory sense were normal. Deep tendon reflexes were 3+ except for the ankle jerks which were faintly responsive. Plantar responses were normal.

Laboratory Data: On admission the hemoglobin was 7.4 gm/100 ml., hematocrit 25%, WBC 9,050, with 60 neutrophils, 31 lymphocytes, and 9 monocytes. Urinalysis showed a specific gravity of 1.015, trace of albumin, negative sugar, and 1-2 white blood cells and moderate bacteria per high power field. Serum ammonia was 123 micrograms/100 ml. (normal less than 100); BUN 6 mg./100 ml., SGOT 86, SGPT 13, total bilirubin 5.6 mg./100 ml. with a one minute bilirubin of 1.8 mg./ml. Alkaline phosphatase was 22 K-A units, glucose 74 mg./100 ml. Prothrombin time was 19 seconds with a control of 13.5 seconds. Total protein was 7.5 gm./100 ml., albumin 1.1 and globulin 6.5. Serologic test for syphilis was negative.

X-rays: Chest x-ray on admission was interpreted as normal. Upper gastrointestinal x-rays revealed equivocal esophageal varices. The stomach, duodenal bulb and loop were normal.

Hospital Course: The day after admission she exhibited fever between 100 and 101.6 degrees F. Sputum culture was negative. Urinalysis showed gram negative rods on a direct smear; culture showed E. *coli* and K. *aerobacter* sensitive to tetracycline, chloramphenicol and nitrofurantoin. She was begun on 500 mg. tetracycline every six hours. Multiple blood cultures were negative. The temperature returned to normal for two days but a low grade fever recurred and continued for the next several weeks. Repeated blood cultures were negative and sputum smear and cultures for acid fast bacilli were negative. Routine sputum cultures revealed no pathogen. Stool examinations for occult blood were positive in approximately half the examinations. Paracentesis fluid contained 0.6 gm. protein/100 ml. but was negative for malignant cells.

Treatment with tetracycline was continued for 18 days. On the 30th hospital day, because of a gradual decline in hemoglobin and hematocrit to 6.9 gm./100 ml. and 21% respectively, three units of whole blood were given over a two-day period. The hemoglobin

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Figure 1. Photograph taken at the time of polyneuropathy showing loss of muscle mass from disuse atrophy.



Figure 2. Photograph taken 16 months later. Note return of normal muscle mass. There was no evidence of neuropathy at this time.

and hematocrit were 10.6 gm./100 ml. and 32% respectively after transfusion. Repeat urine culture showed *proteus morgagni* sensitive to chloramphenicol, nitrofurantoin and streptomycin. Nitrofurantoin therapy was started on the 30th hospital day, 100 mg. with meals and at bedtime. On the day after beginning nitrofurantoin therapy she began to complain of paresthesia of hands and feet. This rapidly progressed, and on the 7th day of therapy she was unable to tolerate covers on her feet because of pain and she refused to stand. Grip in the upper extremities was markedly weakened so that she was unable to hold a glass in her hand. Nitrofurantoin therapy was discontinued after one week, on the 37th hospital day. Lumbar puncture was performed on the 39th hospital day. Normal pressures were obtained, total protein was 27 mg./100 ml., and no cells were present. Oral therapy with multivitamin tablets and thiamine chloride was begun. EEG was normal. Subsequent EEGs were unchanged except for a slightly slow rhythm. Eventually catheterized urine specimen showed a negative smear and culture.

Muscles of the arms, legs and hands became markedly atrophic (Fig. 1). The temperature remained normal. She remained in the hospital for an additional two months receiving physiotherapy; however, on discharge she was still unable to walk because of muscle weakness and severe paresthesia. Adequate sensory testing was unable to be performed because of poor cooperation of the patient. Liver biopsy was not performed because of a persistently prolonged prothrombin time. Laboratory data prior to discharge revealed total protein 7.2 gm./100 ml. with albumin 2.4 gm./100 ml., gloubulin 4.8 gm./100 ml., total bilirubin 0.9, alkaline phosphatase 8.7 K-A units, SGOT 35, SGPT 11, hemoglobin 10.3 gm./100 ml., hematocrit 30%, white count 4694, with 68 neutrophils, 30 lymphocytes and 2 monocytes. Cephalin floc. was 4+, thymol turbidity 5.8 units.

Subsequent Course: The patient was seen again two months after discharge. She was still unable to stand because of weakness and paresthesia. Laboratory data revealed a hemoglobin of 12.9 gm./100 ml., hematocrit 39%, white count 6950, with 56 neutrophils, 32 lymphocytes, 11 monocytes and 1 eosinophil. Prothrombin time was 21.5 seconds with a control of 15 seconds. Six months after her discharge from the hospital all her muscle strength returned and her paresthesia had disappeared. She was lost to follow-up and was not seen for the next 16 months when she was readmitted for an episode of upper gastrointestinal bleeding related to her alcholism. At this time no muscle wasting was noted. There was no evidence of neuropathy. (Fig. 2).

Discussion: Polyneuropathy due to nitrofurantoin therapy has not been generally recognized. Only about 26 cases are reported in the world literature. Polyneuropathy due to this drug might be predictable, however, since some of the other nitrofurans have been shown to cause neuropathy.

Furaltadone therapy was associated with many cases of peripheral neuropathy[1]. Collings[2] in 1960 reviewed polyneuropathy associated with nitrofuran therapy; he reported a patient with embryonal cell carcinoma of the testis with metastases who was treated with cobalt and nitrofurazone (Furacin®) 1.5 gm. daily, supplemented by large doses of vitamins and crude liver extract. The patient developed a severe polyneuropathy and at autopsy showed severe disintegration of myelin sheaths in the preipheral nerves and in the dorsal and ventral roots. The use of nitrofurazone in the treatment of carcinoma is based on the finding of disintegration of the seminiferous epithelium in animals produced by the nitrofuran. In his review, Collings also presented three patients who developed paresthesia and muscular weakness on treatment with nitrofurantoin. Some degree of improvement was found in all three in discontinuing the drug.

Other cases of peripheral neuropathy have been recorded recently[3-7]. Ellis' six cases[4] all had varying degrees of renal failure. In three of the patients the drug was not withdrawn and death occurred. Loughrige's case[3] also had a severe degree of renal failure. Plasma levels of nitrofurantoin were extremely high. Autopsy showed swollen peripheral nerves with interstitial edema but no inflammatory cells. Nerve bundles and nerve fibers were uniformly atrophic and showed Wallerian degeneration. Uesu's case[7] had moderate renal failure and was also in a state of poor nutrition. It was stated that he consumed a moderate amount of alcohol but no liver biopsy was available. This patient sustained severe and permanent peripheral neuropathy following treatment with nitrofurantoin for six weeks.

Although it might be argued that our patient was a candidate for the development of alcoholic polyneuritis, the rapidity of onset following the adminis-

tration of nitrofurantoin as well as her gradual recovery on cessation of the drug makes it most likely to be related to administration of nitrofurantoin. Certainly the poor nutritional state may have made her more susceptible to drug induced polyneuropathy. Since some patients have developed polyneuropathy while receiving vitamin B, a simple vitamin deficiency seems unlikely to be mechanism of production of this complication.

Uesu[7] postulates that the common denominator of the mechanism of the various etiologies of peripheral neuropathy is a disturbance of enzymatic control of carbohydrate metabolism. Nitrofurans probably act as an enzyme inhibitor in bacterial cells and in testicular and nerve tissues.

Martin, *et al*[6] mention that anemia is a relative contraindication to treatment with nitrofurantoin but therapy during anemic states has not been well studied. Our patient was mildly anemic due to gastrointestinal blood loss during nitrofuran therapy. There was no evidence of hemolysis. This is believed to be the first reported case of nitrofurantoin induced polyneuropathy in which alcoholism and cirrhosis was the underlying condition. Uesu's case had a history of alcohol ingestion but had moderately advanced renal failure as well.

Although polyneuropathy due to nitrofurantoin is relatively uncommon considering the frequency of use of this drug, certain cautions should be observed. Any degree of renal failure contraindicates its use for two reasons. If nitrofurantoin is given in the usual doses in renal failure, extremely high blood levels will result. Also, since effective antibacterial levels normally are only obtained in the urine with the drug, the presence of renal failure decreases the concentration of the drug in the urine. Debilitated states such as this patient exhibited probably predispose to the development of nitrofurantoin polyneuropathy.

Summary

A case of severe peripheral polyneuropathy associated with short therapy with nitrofurantoin is presented. The patient had no evidence of renal failure but anemia and alcoholism were present. This is believed to be the first case of severe polyneuropathy in which alcoholism and cirrhosis were the basic underlying conditions. Recovery occurred slowly in six months after discontinuance of the drug. Nitrofurantoin is contraindicated in the presence of renal failure. Caution is urged with its use in debilitated or anemic patients.

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Please

Be sure to complete and mail the very brief questionnaire on page 45

SPECIAL ARTICLES

Medical Disaster Preparedness †

MAJOR SAM K. BRIDGERS, JR.*

Louisville, Ky.

NUCLEAR attack upon the United States is a *real* possibility. At the same time, there is an increasing realization that recovery from such an attack is just as real a possibility. People are our nation's most precious resource. In a disaster, organized groups of people accustomed to working together can be invaluable.

Since the keystone of our democratic social relationship is the family group, we therefore want to plan not only for our community, state and nation, but plan for ourselves and our families. Your chance of surviving a large disaster or nuclear attack is negligible if you are not prepared for it—prepared as an individual, as a member of your family and as an integral part of your community.

The physical ability of our society to survive even the most terrifying nuclear attack is a factor of crucial importance to our national security. The ability to survive, coupled with the will to do so, ranks ahead of our military power as the most conclusive demonstration of our determination to deter any aggression; and the best assurance of continued freedom. Our government echoes the will of the individual. If this will is backed up with a demonstration of our abilities to survive on the home front, then a potential aggressor must not only overcome our military power, but must fight the courage and convictions of each and every person in this great nation of ours. The key to survival is individual action—individual action by *you!*

It has been twenty years since we dropped the Atom Bomb on Japan. The memory of this most terrifying force ever unleashed still burns in our memory. It is a disgrace that this fantastic source of energy should be first used to destroy human life. Through the vision and determination of our scientists, we are now beginning to reap the rewards of nuclear energy. It is not uncommon to provide electrical power by using nuclear energy, nor is it an uncommon occurrance to use radioisotopes in medicine and industry. Of course, we have taken advantage of this unlimited source of energy to run aircraft carriers, submarines and to improve our military kill-ability by attaching a nuclear warhead to an intercontinental ballistic missile.

What does all this mean? Why have I taken the last few moments telling you about something you already know? My purpose is to emphasize to you that we are surely standing on the precipice of our future. The future of the last 300 years, yes—even the past 2,000 years, is in our hands today! You and I truly hold the destiny of our families, our community and our nation in our decision to take or not to take action today.

Which shall it be? Are we going to continue down the road of unpreparedness? Are we going to lose the struggle of freedom by turning the other way—because we are too busy?

Gentlemen, the time is short. Twenty years have passed. Khruschev has openly sworn to "bury us". The Communists are sincere in their intent to conquer the world. They are prepared and have demonstrated their intent in many places—yes, even ninety miles from our own shores. Let me point out an event that happened yesterday dealing with the other large member of the Communist Party, China. Secretary of State Dean Rusk has announced (and I quote) that Red China may explode a nuclear device "in the near future", and if so, the United States Government will announce it. U. S. authorities reported that information from a variety of sources now indicates that Communist China could set off its first atomic bomb at any time, but it will still take the Chinese years to develop a modern delivery system capable of carrying nuclear warheads to their targets."

We should all be aware that the Nuclear Test Ban Treaty was not signed with Communist China. But, for that matter, when has any Communist lived up to an agreement, particularly concerning matters of their own ambitions? It is interesting to note that approximately two years ago it was reported that Communist China's nuclear reactor exploded and that most of their leading scientists were killed in this explosion. At that time, it was estimated that it would take another five years, at least, to develop this same nuclear capability. As so often in the past, we have grossly underestimated the determination and abilities of our enemies. What more evidence do you need? Are you going to sleep too long and wake up in bondage, like Rip Van Winkle?

There are three basic building blocks that must be strong and firmly bonded together to provide a work-

†*Presented at the Third General Scientific Session of the 1964 KMA Annual Meeting September 29-October 1, 1964.*

**Director of Civil Defense, Louisville and Jefferson County.*

able and sensible survival plan. We must have a good warning system; shelter for all to be protected from radiation, and—perhaps most important of all—education to develop the talents needed for survival.

If your city and county has a full-time paid Civil Defense director and a realistic workable budget, he can provide you with an adequate warning and shelter system. As the first vice president of the Kentucky Civil Defense Council, I have discovered that it is not uncommon for most counties in Kentucky not to have a full-time paid Civil Defense director, and, even more startling, no money has been provided to even start an effective Civil Defense program! If this is true in your area, I urge you to confront your county judge with this fact and demand that he accept his legally acquired obligation and establish a workable Civil Defense program at once. If a nuclear war were waged on the United States, it is on record that Kentucky is not a logical ballistic missile target. Kentuckians should have only the problem of protecting themselves against fallout. The old argument that we can't survive the immediate effects of a nuclear explosion is not a valid argument for Kentuckians. Our problem will be protecting ourselves from radiation caused by fallout. There is not a logical reason that has been or can be advanced that eliminates the necessity of a full-time Civil Defense program. The responsibility of a similar program in your community belongs to your county judge. However, it is your obligation to let him know that you, as a respected, leading citizen of your community, want an effective civil defense program.

You wouldn't think of eliminating the police or fire departments; of eliminating sanitation controls or eliminating innoculation programs. You know from experience that these preventive measures, and many others, have reduced loss of life and property. Why do you turn your backs on the problems brought on by the nuclear age? We know from testing that there are basic methods that can be used to provide "survival insurance" against the effects of a nuclear war. They are: education and training, warning and communications and shelter.

What is your role in the Civil Defense program? First, because of your prominent and respected position in your community, you must shoulder the burden of being an example for others to follow. You, as a medical doctor, know the people of your community more intimately than anyone else. It is you who have brought so many of your neighbors into this world. It is you who have offered your talents to render aid to the sick. It is you who keeps your community healthy and thriving. The die has been cast. Your role of leadership is well founded in the heritage of your profession.

Show them through education and training that the fears of the nuclear age can be reduced. Show them how to cope with problems of this age. How can you do this? It is really quite simple. All it takes is some of your time and the application of your intelligence to the problem.

First, start a Medical Self-Help Training program by enrolling yourself—and all medically trained personnel in your community.

Second, teach graduates of this first Medical Self-Help class to become instructors to in turn teach this course to at least one member of every family in your community.

Next, get together with your civil defense director, your hospital administrator, your police and fire chiefs and develop a community and hospital emergency survival plan.

After shelters have been established, see to it that they are stocked with emergency supplies. Also, follow through and help with the teaching of qualified persons to run the shelters. The Civil Defense course called "Shelter Management" is designed to do just this.

You will be especially invaluable in teaching another Civil Defense course—"Radiological Instrument Operators". Without the ability to read the radiological instruments, it would be the same effect as trying to drive a car blindfolded.

In conclusion, you've heard the background, the challenge and your part of the solution. If you don't become part of the solution, you will remain part of the problem.

March 18

Circle this date on your calendar

for the 1965 KMA Interim Meeting

EDITORIALS

Our Questionnaire

ON PAGE 45 of this issue will be found a short questionnaire which we trust you will take time to complete and return to this office. There is a two-fold objective in presenting this to you.

We constantly seek to improve this Journal so that it will be more attractive and more profitable to our readers. Of course, the primary aim is to put in your hands scientific discussion which will prove helpful in your practice to the end that better medical care may be provided.

The articles selected for publication cannot be interesting and helpful to every reader at one time: the diversity of interest in the fields of research, public health, specialities, and general practice must be taken into consideration. We seek to provide as even a distribution of material on this basis as is possible. Your opinions will prove helpful in the accomplishment of this purpose.

The Journal cannot subsist economically without the support of our advertisers. The competition for good and constructive has become highly competitive and State Medical Journals, because of their limited distribution, are in an unfavorable position in this regard. Reasonable attention of our readers to advertising display, and expression of their preference will be helpful in our relation to the pharmaceutical houses and other agencies which help to support us.

Your prompt cooperation in completing the questionnaire and in offering suggestions for the improvement of the Journal both in scientific and advertising content is respectfully solicited.

SAM A. OVERSTREET, M.D.

Some Immature Impressions

IT WAS recently our privilege, along with about 50 other United States physicians, to attend the Eighth International Congress of Internal Medicine at Buenos Aires, Argentina. There were five principal subjects under discussion: (1) Iatrogenic Diseases; (2) The Internist and His Role in Medicine; (3) Diseases Particularly Related to the Geographical Areas in the Americas; (4) Chromosomes and Pathology; (5) Para-neoplastic Syndromes. While the majority of presentations came from South American countries, principally Argentina, there were altogether thirty nations represented on the Program.

One handicap of such a meeting is the lack of understanding of papers presented in a language of which the hearer has no knowledge. Simultaneous translation is provided, but even at that one may often obtain only the most sketchy impression of the essayist's intent. Fortunately a reasonable percentage of the papers are presented in English and most of the others are summarized in English so that one may obtain fair comprehension of the subject matter presented.

It was anticipated that attendance at the Conference would be about 750 physicians. It was reported that after the registration passed 2000 they stopped counting. At any rate, the interest and attendance was beyond expectation.

We as American physicians tend to be rather complaisant and smug with regard to our place of superiority in the medical sun. We are inclined to feel that our system of education and

post-graduate training is superior, and perhaps it is. It is stimulating, however, to meet with other physicians in an entirely different environment and to learn that they too are performing well in the field of medical science, that they have excellent facilities for clinical training and research, and contribute much to the world-wide progress of medicine. Diseases, which are exceedingly rare in our experience and about which we learn only from reading, are constant clinical problems with them.

We were afforded an opportunity to visit some of the medical schools and hospitals in Argentina and Brazil. They have a premedical and medical school training that appears to differ rather widely from ours, but seems arranged to allow ample opportunity for thorough and mature education in medicine. Apparently much depends upon the student's individual effort. It would appear that they have fewer full time faculty members and make a greater use of part time clinical teachers than we do at present in our American schools.

At Rio de Janeiro on December 3rd we were invited to attend a morning clinical conference by Dr. J. P. Lopes Pontes, Professor of Medicine of The National Faculty of Medicine of the University of Brazil, assisted by ten members of his full time and clinical faculty. We were provided with the following printed program.

UNIVERSIDADE DO BRASIL
FACULDADE NACIONAL DE MEDICINA
Rio de Janeiro
CLINICAL MEETING, ORGANIZED BY
PROFS. CLEMENTINO FRAGA FILHO,
J. RODRIGUES DA SILVA AND
J. P. LOPES PONTES
Hospital Sao Francisco de Assis—December 3, 1964

* * * *

Cutaneous manifestations of collagen diseases
—Dr. Sylvio Fraga
Strongyloidiasis: clinical and pathological aspects
—Dr. Faustina Porto
Bronchography using barium suspension
—Dr. Jesse Teixeira
Pathology of Schistosomiasis Mansoni
—Dr. Comingos de Paola
Hemodynamic studies in Schistosomiasis Mansoni
—Prof. J. Rodrigues da Silva
Clinical study of renal functions with radio-isotopes
—Dr. Mauricio S. Basseres
Surgical experience with grafts for correction of arterial lesions
—Drs. Sydney Arruda and Carlos J. Brito
Liver diseases and auto-immunologic mechanisms
—Dr. Jorge Toledo

Every subject was presented briefly and concisely in excellent English. We were then entertained briefly in the library of the hospital by an informal and very pleasant coffee hour.

It is all the more surprising that this program was put together on 36-hour notice. Every participant appeared on time and stayed for the coffee hour that followed. One is bound to speculate as to how well and courteously the faculty members of one of our own medical schools would have responded to such a challenge. We might have scared up a program but to present it in Portugese would have slowed us down!

Our hospitals and institutions of medical training are filled with foreign students, residents, and research workers. Because of language barriers and personality differences it is not always easy to be patient and considerate of foreign members of our house staff and try to impart to them during this period of training here as much as we can of our medical knowledge and methods.

This recent experience in South America, particularly the impromptu clinical program conducted by Professor Lopes Pontes and his staff, underscore the opportunity that we have in our own institutions for promoting good fellowship and understanding to the visitors within our gates. In a few years they will carry back to their home locality a sense of good will and appreciation or else a feeling of frustration and disappointment. It is an area in which many of us may well do better in the future than we have done in the past.

SAM A. OVERSTREET, M.D.

ORGANIZATION SECTION

Interim Meeting Talks to Cover Wide Variety of Subjects

Topics of great interest to Kentucky physicians will be discussed by five well-informed speakers at the 1965 KMA Interim Meeting March 18 in Owensboro, Delmas M. Clardy, M.D., Hopkinsville, KMA president, said recently.



Mr. Stark

Nathan J. Stark, L.L.B., Kansas City, Mo., vice-president of the Board of Directors of Hallmark Cards, Inc., and a member of the Research and Planning Council of the American Hospital Association, will speak on "A Consumer and Hospital Trustee Looks at Areawide Hospital Planning".

Mr. Stark, a graduate of the Chicago Kent College of Law, is president of the Kansas City General Hospital and Medical Center Corporation. He is also chairman of the city Metropolitan Hospital Planning Committee and a member of the Task Force of the National Commission on Community Health Facilities. His past civic services and activities, both national and local, are too numerous to mention. He is widely known for his speeches and publications on the subject of health facilities.

"Interprofessional Relations—a Two-Way Street" will be the topic of Mr. Robert E. Lee, Tucson, Ariz., a member of the Council of the American Pharmaceutical Association. A graduate of the Washington State University College of Pharmacy, Mr. Lee managed and owned community pharmacies in Seattle from 1946 to 1964.



Mr. Lee

He is a Fellow of the American College of Apothecaries, and a past board member and Regional Director of that organization. Mr. Lee's address, scheduled for the morning session, will cover the important subject of bettering professional relationship between physicians and pharmacists.

Another nationally-known speaker, Austin Smith, M.D., former editor of the Journal of the American Medical Association and currently president of the Pharmaceutical Manufacturers' Association, will provide a most interesting discussion at the luncheon session, Doctor Clardy said. Doctor Smith's topic, as well as particulars on other speakers and their participation in the program, will be carried in the February issue of The Journal.

Gabe's Restaurant, Owensboro, will be the site of this year's Interim Meeting and the day-long meeting of the Board of Trustees on the previous day. The Board of Trustees of the Woman's Auxiliary to KMA will also meet on March 17. Accomodations are available at Gabe's Motor Inn, adjacent to the restaurant. Members wishing to attend are urged to make their reservations early.

One Minute — PLEASE

An important brief questionnaire designed to improve your Journal is to be found on the detachable card opposite this page. YOUR prompt response will help us to serve you more efficiently. One brief minute is all we ask. Please use the minute to fill out the card and drop it in the mail—you don't need a stamp.

Thank you —

The Editors

Programs on Organized Medicine Urged for County Meetings

In his report to the KMA House of Delegates during the 1964 Annual Meeting, George P. Archer, M.D., Prestonsburg, then president of the Association, recommended that:

"All county medical societies schedule at least one meeting a year for the purpose of communicating to its members developments in medical organization work of such interest to them. We urge the use of the following sources—KMA officers, AMA delegates or alternates, and members of the KMA Headquarters Staff to assist you."

The House of Delegates then approved the recommendation.

The Executive Committee, in implementing the action of the House, directed that Doctor Archer's recommendation be published in The Journal of KMA. Some of the subjects that might be included in this recommendation would be legislative matters, special county society problems, KMA services, or socio-economic developments.

Any county society wishing to have such a program may contact the KMA Headquarters Office for assistance.

Dr. Hall is New Insurance Editor For Journal of KMA

William W. Hall, M.D., Owensboro, was chosen by the KMA Executive Committee at its November 12 meeting as the new editor of the Insurance Page of The Journal. Doctor Hall replaced W. Vinson Pierce, M.D., Fort Thomas, editor for the past five years, who resigned.



Doctor Hall

Doctor Hall is a member of the KMA Advisory Commission to Blue Shield and is an alternate delegate to the American Medical Association.

He serves on the Board of Directors of KEMPAC (Kentucky Educational Medical Political Action Committee) and is president of the Daviess County Medical Society. A 1954 graduate of the University of Louisville School of Medicine, Doctor Hall also serves on the Owensboro-Daviess County Board of Health.

Dr. Ward Asks For Dedication, Unity, in AMA Address

Donovan F. Ward, M.D., Dubuque, Ia., president of the American Medical Association, called for continued unity and dedication of the nation's physicians in their fight against socialized medicine in his address to the first session of the AMA House of Delegates at the Miami Beach Winter Clinical Conference.

Doctor Ward disagreed with the theory that Medicare-tax legislation will be easily passed during the current congressional session.

On the same subject, the AMA president discussed the goals of medicine in protecting the patient; utilization of the Kerr-Mills law by the states; flexible, voluntary retirement programs in industry; and the right of the citizen to spend his own money as he chooses, rather than government dictation of spending.

Doctor Ward's address was received enthusiastically by AMA members; at its conclusion he was given a standing ovation with lengthy applause.

Dr. Murphy on Sports Program

Owen B. Murphy, M.D., Lexington, University of Kentucky team physician, explained the aims of the Sixth National Conference on the Medical Aspects of Sports at the opening session of the conference held November 29 in Miami.

Doctor Murphy, who was program chairman for the Conference, said that a number of Kentucky physicians attended the day-long meeting. The conference was held as an adjunct of the AMA's Winter Clinical Convention.

Dr. Clardy to Discuss Socialism At Meeting of First District

"The Key to Socialism" will be the topic of Delmas M. Clardy, M.D., Hopkinsville, KMA president, guest speaker at the First Trustee District Meeting January 22 at Paducah, according to O. Leon Higdon, M.D., Paducah, First District Trustee.



Doctor Clardy

Doctor Higdon, who is in charge of the meeting, said that all members of the First District are invited to attend the meeting. He stated that an interesting and important program has been planned for the evening.

The session, at Boswell's Restaurant in Paducah, will begin with a social gathering at 6:30, and dinner will be served at 7:00 p.m.

Help—Your Secretary

KMA and AMA 1965 membership dues are now being remitted to the KMA membership office, Delmas M. Clardy, M.D,. Hopkinsville, KMA president, said recently. Dues are counted as delinquent if not received by April 1. Doctor Clardy urged members' cooperation in sending checks promptly to their county society secretaries in order to save time and make the work less complicated.

New KEMPAC Board Appointed by KMA Trustees

The Board of Directors of the Kentucky Educational Medical Political Action Committee was reconstituted as provided for by the KEMPAC Bylaws at the December 10 meeting of the KMA Board of Trustees.

The KEMPAC Board is made up of a physician from each Congressional District, three members at large, and a representative from the Women's Auxiliary to the Kentucky Medical Association. Members of the Board are named annually by the Board of Trustees.

The New KEMPAC Board will meet in January and organize, according to Hoyt D. Gardner, M.D., Louisville, who is retiring as chairman and as a member of the Board.

The new members of the Board are: First District, Joseph R. Miller, M.D., Benton; Second District, Daryl P. Harvey, M.D., Glasgow; Third District, Richard F. Greathouse, M.D., Louisville; Fourth District, Carl Cooper, Jr., M.D., Bedford; Fifth District, Harold B. Barton, M.D., Corbin; Sixth District, David B. Stevens, M.D., Lexington; Seventh District, Charles C. Rutledge, M.D., Hazard; W. Donald Janney, M.D., Covington; Walter L. Cawood, M.D., Ashland; W. Gerald Edds, M.D., Calhoun; and Mrs. Arthur Holmes, Corbin.



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Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

- lowers motility promptly
- relieves spasm promptly
- stops diarrhea promptly

Lomotil fulfills the first order of treatment in most patients with diarrhea — prompt symptomatic control.

Pending discovery of the cause, early cessation of diarrhea is almost always urgently indicated. Prompt symptomatic control averts distress, dehydration and, frequently, severe exhaustion.

Both experimental and clinical evidence indicates that Lomotil exerts such control efficiently, safely and with maximal promptness.

dosage:

The recommended initial *adult* dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months, to 10 mg. for one 8 to 12 years of age.

cautions and side effects:

Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE

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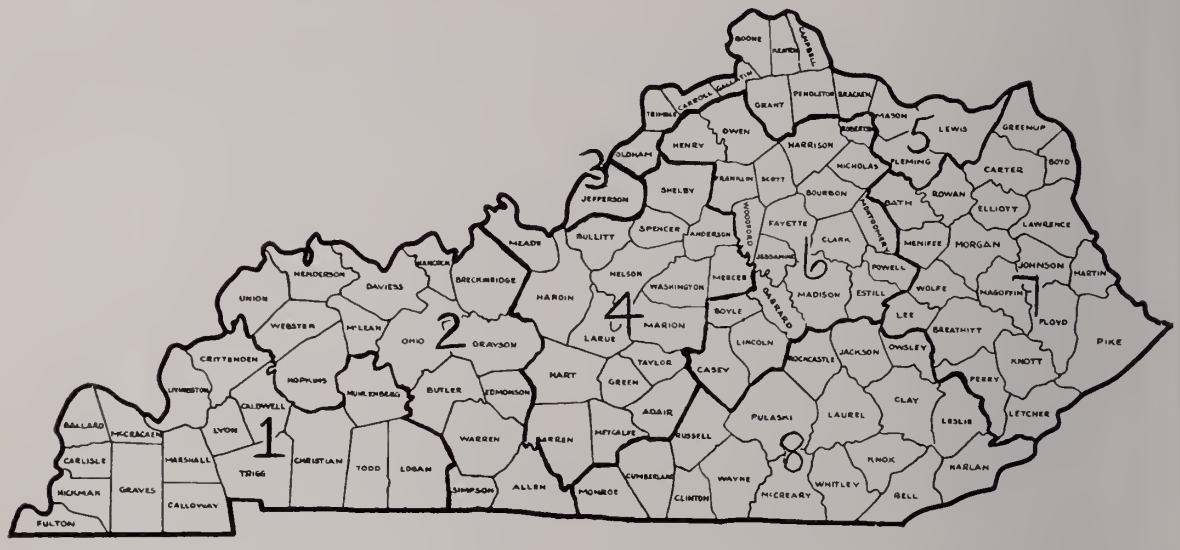
Numerous proposals which would change the pattern of medical care in this country will be presented to Congress during its current session. These are most important to the public and medical profession.

For this reason, John C. Quertermous, M.D., chairman of the KMA Council on Legislative Activities for National Affairs, asks all physicians to follow very closely developments in the months ahead.

Doctor Quertermous urges all physicians to become acquainted with their congressmen and points out that the congressman is interested in having the views of his constituents.

The Journal of KMA, in order to assist you in accomplishing this, gives the following information for you. You may want to remove this page and keep it in your files. Your congressman may be reached by addressing him at the House Office Building, Washington, D.C.

Kentucky's Seven Congressional Districts



CONGRESSMEN*

District

1 Frank A. Stubblefield (D), Murray

2 William H. Natcher (D), Bowling Green

3 Charles Farnsley (D), Louisville

4 Frank L. Chelf (D), Lebanon

5 Tim Lee Carter, M.D., (R), Tompkinsville

6 John C. Watts (D), Nicholasville

7 Carl D. Perkins (D), Hindman

Address Congressmen at House Office Building, Washington, D. C.

SENATORS*

John Sherman Cooper (R), Somerset

Thruston B. Morton (R), Louisville

Address Senators at Senate Office Building, Washington, D. C.

Dr. Noback to Assume High Post At Missouri Medical Center

Richardson K. Noback, M.D., associate professor of medicine at the University of Kentucky Medical Center and an active participant in the affairs of KMA, recently accepted the post of Executive Director of Kansas City, Mo., General Hospital and Medical Center, effective January 1.

Doctor Noback, whose title will include that of Associate Dean of the University of Missouri for the Kansas City Medical Center, and professor of medicine, will have charge of the extensive development program being planned for Kansas City.

A graduate of Cornell University School of Medicine, Doctor Noback has been with the U.K. Medical Center since its inception. He is a former member of the KMA's AMA-ERF Committee, and has, since 1962, been a member of the Scientific Exhibits Committee.



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Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention...the enteric coating assures gastric tolerance...and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

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In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

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AMA PRESIDENT-ELECT James Z. Appel, M.D., right, received congratulations from President Donovan F. Ward, M.D., following Doctor Appel's election during the AMA's Winter Clinical session in Miami Beach last month. Doctor Appel will be inaugurated in June at the AMA Annual Meeting in New York City.

Dr. Appel to Head AMA in 65-66 Will be Installed in June

James Z. Appel, M.D., Lancaster, Pa., vice-chairman of the Board of Trustees of the American Medical Association, was chosen president-elect of the AMA during the Association's winter Clinical Convention in Miami November 29-December 2.

Doctor Appel will take office at the AMA Annual Meeting in New York City in June, succeeding Donovan F. Ward, M.D., Dubuque, Ia., who has held office since the death of President Norman A. Welch, M.D., in September.

Under the Bylaws of the AMA, if the president dies before the fall interim meeting, the president-elect succeeds and holds office until the following June. He is then succeeded by the new president-elect, chosen at the interim session. Doctor was elected at San Francisco in June, 1964.

The new AMA president, Doctor Appel, has a long record of service to the medical profession. He has served as a member of the AMA Board of Trustees since 1957. A surgeon and general practitioner, he served ten years on the Board of Trustees of the Medical Society of Pennsylvania and is a past president of his county medical society. Doctor Appel is a member of the American College of Surgeons.

Senior Day Programs Planned For U. of K. and U. of L.

KMA Senior day programs will be held for the University of Louisville School of Medicine Seniors on March 15 and the Seniors at the University of Kentucky College of Medicine on April 13, according to an announcement by Carl C. Cooper, M.D., Bedford, KMA Senior Day Committee chairman.

The program at the University of Kentucky will be the second such event presented for the school by the KMA in cooperation with the Fayette County Medical Society and the College of Medicine.

The Eleventh Annual Senior Day program at the University of Louisville will be presented with the cooperation of the School of Medicine and the Jefferson County Medical Society.

Speakers for the programs have not yet been confirmed, Doctor Cooper said, though it is expected that the names of the speakers and their topics will be available for the next issue of The Journal.



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BRIEF SUMMARY

'SOMA' COMPOUND; 'SOMA' COMPOUND plus CODEINE: carisoprodol, acetophenetidin, caffeine, codeine phosphate. *Warning: Codeine may be habit-forming.* **Indications:** 'Soma' Compound and 'Soma' Compound with Codeine are indicated for relief of pain and stiffness in traumatic, rheumatic and other similar conditions. **Contraindications:** Allergic or idiosyncratic reactions to carisoprodol or codeine. **Precautions:** *Acetophenetidin*—May damage the kidneys when used in large amounts or for long periods. *Codeine*—Should be used with caution in addiction-prone individuals. *Carisoprodol*—Like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate. **Side effects:** *Codeine*—Nausea, vomiting, constipation, and miosis. *Carisoprodol*—The only side effect reported with any frequency is drowsiness, usually on higher than recommended doses. One instance each of pancytopenia and leukopenia occurring when carisoprodol was administered with other drugs has been reported as has an instance of fixed drug eruption with carisoprodol and subsequent cross-reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. Other rarely observed reactions have included dizziness, ataxia, agitation, increase in eosinophil count, and gastrointestinal symptoms. Massive overdosage may produce coma and/or mild shock and respiratory depression. **Dosage:** 'Soma' Compound and 'Soma' Compound with Codeine, one or two tablets three times daily and at bedtime. **Supplied:** 'Soma' Compound, orange tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., and caffeine 32 mg. 'Soma' Compound with Codeine, white, lozenge-shaped tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., and codeine phosphate 16 mg. Narcotic order form required. *Before prescribing, consult package circular.*

CSO-3518

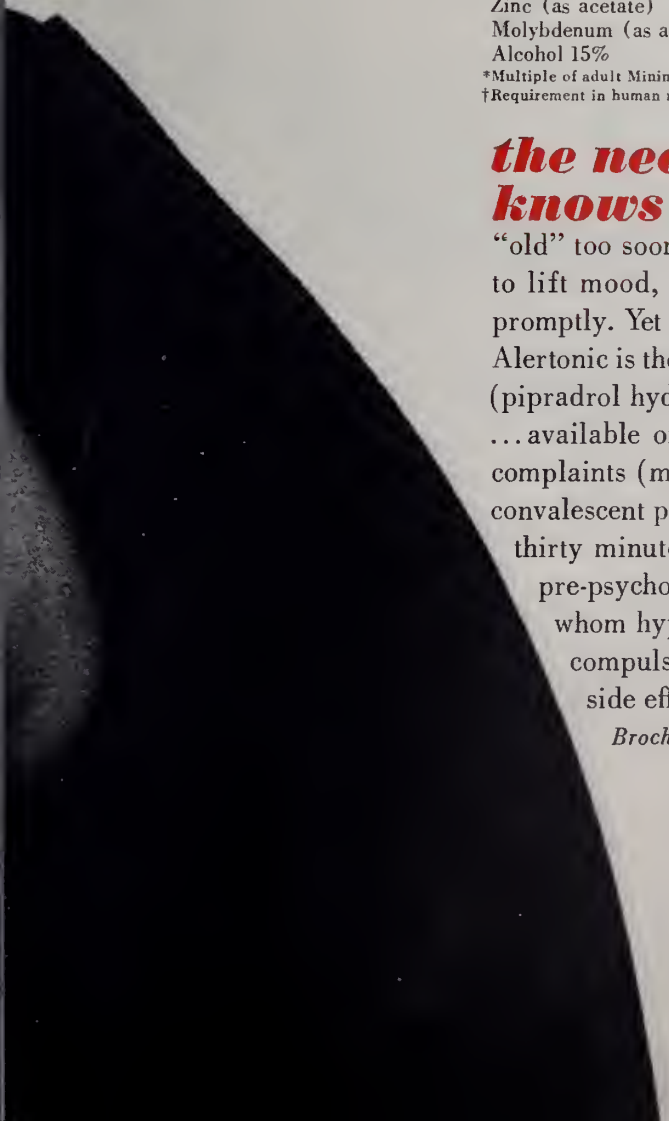
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Pipradrol hydrochloride	2 mg.
Vitamin B_1 (thiamine hydrochloride) (10 MDR*)	10 mg.
Vitamin B_2 (riboflavin) (4 MDR*)	5 mg.
Vitamin B_6 (pyridoxine hydrochloride)	1 mg.
Nicotinamide (5 MDR*)	50 mg.
Choline†	100 mg.
Inositol†	100 mg.
Calcium glycerophosphate (2% MDR for calcium and phosphorus)	100 mg.
Cobalt (as chloride)	1 mg.
Manganese (as sulfate)	1 mg.
Magnesium (as acetate)	1 mg.
Zinc (as acetate)	1 mg.
Molybdenum (as ammonium molybdate)	1 mg.
Alcohol 15%	

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†Requirement in human nutrition not yet established

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Anyone can feel tired and "old" too soon. In such functional fatigue, Alertonic helps to lift mood, revive interest, restore purposeful activity promptly. Yet it contains no MAO inhibitors, no hormones. Alertonic is the effective formulation of a cerebral stimulant (pipradrol hydrochloride), alcohol, vitamins, and minerals ... available on prescription *only*. For common functional complaints (mild mood depression, tiredness); geriatric or convalescent patients, Rx one *tablespoonful* Alertonic *t.i.d.*, thirty minutes before meals. Contraindicated in agitated pre-psychotic patients, paranoia, or other patients in whom hyperexcitability, anxiety, chorea, or obsessive-compulsive states are present. Mild central stimulant side effects may occasionally occur.

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Kentucky Well Represented at AMA Miami Beach Sessions

Registration figures for the American Medical Association's Winter Clinical Convention in Miami Beach November 29-December 2 totaled 9,356, according to the last available report.

Kentucky Physician-registration totaled 53, according to Lloyd W. Prang, manager of the AMA Physicians' Records Section. Following is a list of Kentucky registrants.

Henry B. Asman, M.D., Louisville
H. K. Bailey, M.D., Ashland
John T. Bate, M.D., Louisville
Charles G. Bryant, M.D., Louisville
Delmas M. Clardy, M.D., Hopkinsville
B. F. Combs, M.D., Lexington
Harry J. Cowherd, M.D., Frankfort
Robert Lich, M.D., Louisville
Robert C. Long, M.D., Louisville
William H. McBeath, M.D., Lexington
Jefe Carter Moore Jr., M.D., Franklin
Wyatt Norvell, M.D., New Castle
Edmund D. Pellegrino, M.D., Lexington
Nicholas J. Pisacano, M.D., Lexington
Donn L. Smith, M.D., Louisville
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Wm. R. Willard, M.D., Lexington
John D. Winebrenner, M.D., Louisville
Carroll L. Witten, M.D., Lousiville
T. H. Biggs, M.D., London
Dorothy Holtgrave, M.D., Louisville
Paul F. Maddox, M.D., Campton
Walter L. Thompson, M.D., Louisville
Joseph Book, M.D., Middlesboro
Ralph J. Angelucci, M.D., Lexington
Earl W. Atherton, M.D., Clay
Lowell J. Black, Jr., M.D., Pikeville
Clyde M. Brassfield, M.D., Elizabethtown
I. K. Edwards, M.D., Madisonville
J. Thomas Giannini, M.D., Louisville
George Gumbert, M.D., Lexington
Wm. W. Hall, M.D., Owensboro
Terrell D .Mays, M.D., Earlington
Howard R. Molony, M.D., Covington
Owen B. Murphy, M.D., Lexington
John S. Oldham, M.D., Owensboro
Leland E. Payton, M.D., Lynch
John C. Quertermous, M.D., Murray
John M. Reed, M.D., Mayfield
Charles C. Rutledge, M.D., Hazard
L. Jack Scott, M.D., Bowling Green
George A. Sehlinger, M.D., Louisville
Stanley E. Smith, M.D., Louisville
Elmer J. Rodenberg, M.D., Henderson
John B. Southard, M.D., Louisville
D. V. Sublett, M.D., Lexington
Ralph E. Westervelt, M.D., Hazard
Carl H. Fortune, M.D., Lexington
M. R. Cronen, M.D., Louisville
Wm. H. Armbruster, M.D., Louisville
Henry F. DeLong, M.D., Louisville
C. J. Scalzitti, M.D., Louisville
Joseph Schickel, M.D., Burkesville

Postgraduate Psychiatric Course For Physicians Starts Feb. 15

A postgraduate course in psychiatry for non-psychiatric physicians will be offered at the Louisville Area Mental Health Center at Norton Infirmary on consecutive Wednesday afternoons for 20 weeks, beginning February 15.

The department of psychiatry at the U. of L. School of Medicine, in cooperation with the Center, will sponsor the course, which offers physicians a further understanding of psychiatric principles and practice. The course has been approved by the American Academy of General practice for one hour of Category I credit for each hour attended.

Applications are due January 20. A $25 fee is required. Information and application forms should be requested from: The Louisville Area Mental Health Center, Norton Memorial Infirmary, 231 West Oak Street, Louisville, Ky. 40203.

Drug Testing Program is Topic At Joint District Meeting

Members of the Fourth, Fifth and Seventh Trustee Districts of KMA heard Jean K. Weston, M.D., director of the AMA department of drugs, describe the new drug testing program of the AMA at a joint Trustee District Meeting held December 17 at Louisville.

Doctor Weston spoke of the new computer system going into operation for the accumulation and analysis of drug-reaction information gathered all across the county. The Fifth District was host at the meeting, held in the Medical Arts Building, following an afternoon sleet storm which reduced the expected attendance.

Alfred O. Miller, M.D., Fifth District trustee, presided at the meeting. Trustees for the other districts are Donald Chatham, M.D., Shelbyville (Seventh), and Dixie E. Snyder, M.D., Springfield, (Fourth).

Dr. Ward Attends Board Meeting

Donovan F. Ward, M.D., Dubuque, Ia., AMA president, lunched with the KMA Board of Trustees December 10 and afterward spoke briefly during a regularly scheduled Board meeting at the KMA Headquarters office.

Doctor Ward was in Louisville to deliver the annual Goodman Lecture that evening before the Jefferson County Chapter of the Kentucky Academy of General Practice and was the guest of Carroll L. Witten, M.D., president of the chapter. While in the city he also gave a brief talk to the students of the University of Louisville School of Medicine.



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Occupational Health Conference Slated March 16 at Lexington

The Governor's first Conference on Occupational and Industrial Health will be held Wednesday, March 16 at the Campbell House in Lexington. All Kentucky physicians are invited.

Registration, beginning at 7:00 p.m., and a mixer, will be held the night before the day-long meeting, according to J. E. Eckerle, M.D., secretary of the Kentucky Industrial Medical Association.

R. A. Kehoe, M.D., director of the Kettering Laboratory of the University of Cincinnati and one of the national authorities on Industrial Health, will be the featured speaker at the Conference.

According to Doctor Eckerle, this Conference is sponsored by the Kentucky Industrial Medical Association. Co-sponsors include the State Department of Health, the University of Kentucky, the American Society of Safety Engineers, the Associated Industries of Kentucky, and the AFL-CIO.

The Conference will be opened by Governor Edward T. Breathitt, Doctor Eckerle said. There will be five discussion groups in the afternoon which will report back to the Conference as a whole at 4:00 p.m.

KMA Council and Committee Reports

Council on Legislative Activities

John C. Quertermous, M.D., Murray, Chairman

Louisville **November 18, 1964**

Meeting for the first time in this associational year, members of the KMA Council on Legislative Activities discussed plans for the coming year. Introduced to the Council for the first time was AMA's new field representative for Kentucky, Mr. Harry Hinton.

There was a general discussion about the national election and the possible effect on medical legislation in the next session of Congress. Reports were given on the "HOPE" education program conducted in October, KEMPAC, plans for the Congressional Dinner in 1965, the future of King-Anderson legislation, the Kerr-Mills program, and matters relating to the Hill-Burton Act. The committee made recommendations to the Board of Trustees for district key-men appointments for the coming year. Plans were made for closer liaison between the Council and the Board of Trustees.

Federal Medical Services Committee

L. F. Beasley, M.D., Franklin, Chairman

Louisville **November 19, 1964**

The Federal Medical Services Committee discussed the two contracts pertaining to medical care between the Kentucky Medical Association and the Federal Government at their recent meeting. Representatives of the Veterans Administration and Kentucky Physicians' Mutual were guests of the committee.

Primary action taken by the committee members was to recommend to the KMA Board of Trustees the approval of a proposed change in the Hometown Medical Care Contract from a fee based on a monetary sum to a fee based on a relative value unit. This contract provides medical care for veterans with service connected disabilities.

Rural Health Committee

Donald L. Graves, M.D., Frenchburg, Chairman

Louisville **December 4, 1964**

The Rural Health Committee reviewed the results of the 1964 Rural Health Conference, which was held in Lexington on October 22. The members discussed recommendations presented at the annual meeting of the Rural Health Council. Donald L. Graves, M.D., Frenchburg, chairman of the committee, announced that next year's Rural Health Conference would be held in western Kentucky according to past record of rotations.

John E. Cotthoff, M.D., Hopkinsville, was recently elected chairman of the Rural Health Council and will serve, along with Doctor Graves, as the KMA representative on the Council. James C. Salato, M.D., Columbia, will serve as an alternate. The next meeting of the committee is scheduled for April, 1965.

Senior Day Committee

Carl Cooper, M.D., Bedford, Chairman

Louisville **December 3, 1964**

The KMA Senior Day Committee has set the dates of Monday, March 15 for the Eleventh Annual Senior Day at the University of Louisville and Tuesday, April 13 for the Second Annual Senior Day Program at the University of Kentucky. No major change was made in the format of the program.

The annual sessions are sponsored by the Kentucky Medical Association in cooperation with the Jefferson and Fayette County Medical Societies, University of Louisville School of Medicine and University of Kentucky College of Medicine.

Technical Advisory Committee on Indigent Medical Care

Clyde C. Sparks, M.D., Ashland, Chairman

Lexington **November 25, 1964**

The Technical Advisory Committee on Indigent Meical Care recently held a meeting at the request of the KMA Executive Committee. The primary purpose was to study some problems and misunderstandings that had been received pertaining to the Medical Assistance for the Aged (MAA) Program. Members of the committee approved some recommendations for presentation to the Board of Trustees.

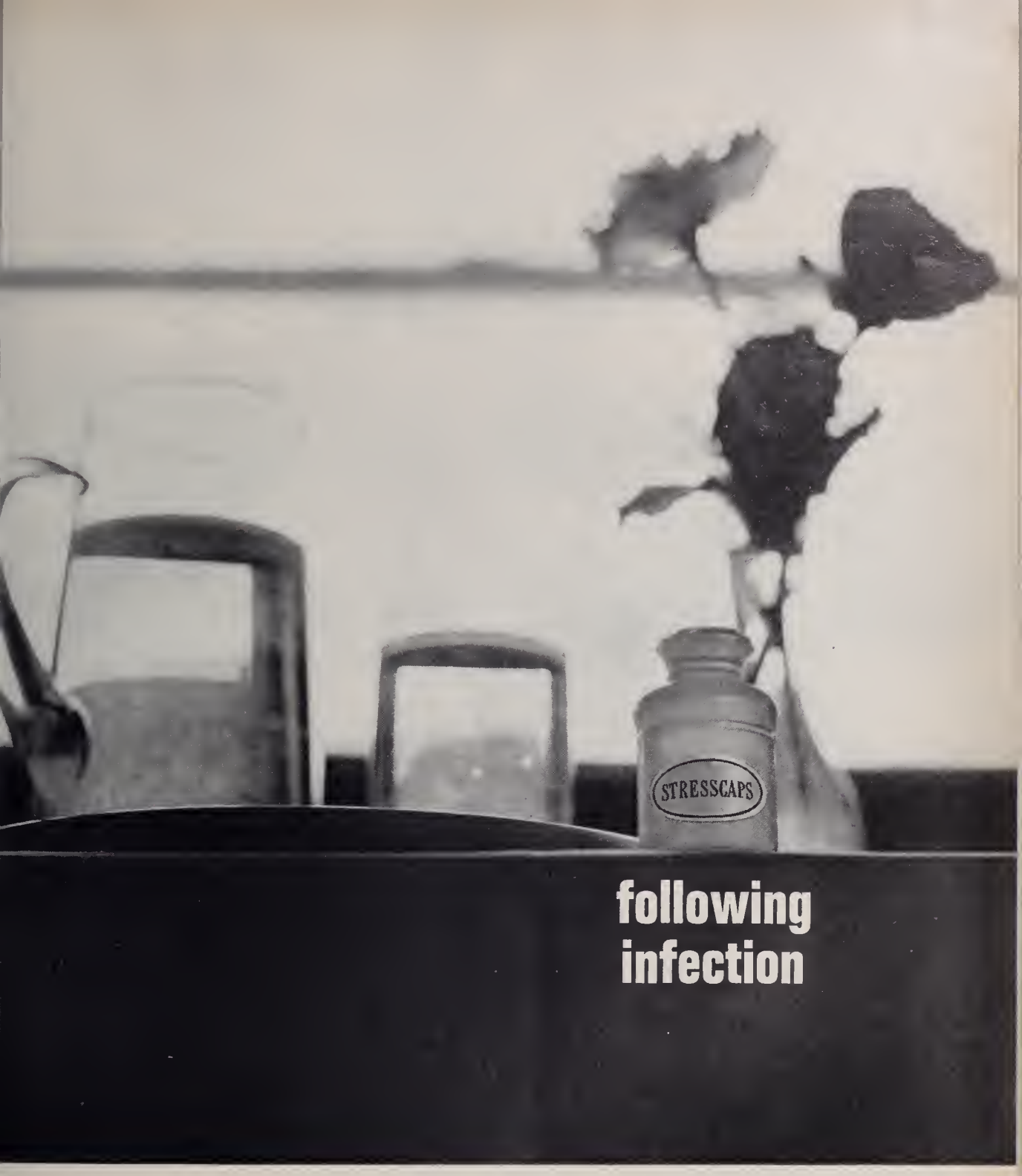
McDowell Home Committee

Laman A. Gray, M.D., Louisville, Chairman

McDowell Home, Danville **November 28, 1964**

Finances, operation and maintenance needs of the McDowell Home were among the items discussed by the McDowell Home Committee when it recently met and inspected the Ephraim McDowell Home. Other matters receiving the committee's attention were the McDowell Library, contributions to the McDowell Library, contributions to the McDowell Fund, and the additions of a Spinet piano and a small kitchenette.

The committee members drafted plans to attract additional physicians interest in and support of the McDowell Home. The next meeting was scheduled for Saturday, March 20, 1965.



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NEWS ITEMS

Carroll L. Witten, M.D., Louisville speaker of the House of Delegates of the American Academy of General Practice and KAGP president, served as chairman of the November meeting of the Surgeon General's Advisory Committee on Indian Health in Washington. The committee meets annually to review the health program conducted for American Indians and Alaska Natives by the U. S. Public

J. Farra Van Meter, M.D., Lexington surgeon, was re-elected president of the Kentucky Council of Churches at a recent meeting in Lexington. **John S. Chambers, M.D.,** Lexington, is executive secretary of the group.

Robert R. Siegel, M.D., an internist, has joined the staff of the University of Kentucky Medical Center's department of Medicine, it was recently announced. Doctor Siegel, a 1955 graduate of the College of Physicians and Surgeons at Columbia University, was a resident at the University of Colorado in Denver, and a Fellow in physiology at the University of Rochester (N.Y.) from 1961-64.

Leonidas Mostowycz, M.D., a radiologist, has joined the staff of the Lexington VA Hospital, where he will practice in association with the University of Kentucky Medical Center. Doctor Mostowycz received his medical degree from Leopold Franzens-Universitat Medizinische Fakultat at Innsbruck, Austria, in 1951, and served residencies in internal medicine and radiology in Europe before completing his residency in this country in 1964.

Leonard S. Reisman, M.D., has joined the faculty of the University of Louisville School of Medicine as assistant professor of Pediatrics. He is also hematologist at Childrens' Hospital. A 1957 graduate of the New York University School of Medicine, he interned at Meadowbrook Hospital, New York City, and was a pediatric resident there. Doctor Reisman was a resident in hematology at Childrens' Hospitals in Michigan and in Los Angeles.

Orville J. Stein, M.D., has started general practice at Winchester, where he will be associated with **Shephen B. Kelley, M.D.,** Doctor Stein is a 1962 graduate of the University of Louisville School of Medicine and completed his internship while in the U.S. Public Health Service at San Francisco. An additional general practice residency was served at Monterey County Hospital in Salinas, Calif.

Benjamin C. Stigall, M.D., has moved from Owensboro to Lexington, where he will limit his practice to otoloryngology. Doctor Stigall is a 1948 graduate of the University of Louisville School of Medicine and interned at Great Lakes Naval Hospital. His residency was completed in 1961 at Dallas VA and Childrens' Hospitals in Dallas, Tex., following several years in general practice.

James A. Meyers, M.D., a radiologist, has become associated with **Edward N. Maxwell, M.D., Frank A. Bechtel, M.D.,** and **Harold Q. Davis, M.D.,** in Louisville.

Doctor Meyers graduated in 1960 from Louisiana State University School of Medicine and interned at Sacred Heart Hospital in Spokane, Wash., before completing his residency at Charity Hospital in New Orleans.

John E. Engle, M.D., has started general practice at Whitesburg, where he will be associated with the Daniel Boone Clinic. A 1963 graduate of Temple University School of Medicine, Doctor Engle interned at Lancaster General Hospital, Lancaster, Pa.

Max P. Jones, M.D., has opened an office at Pikeville for the practice of internal medicine, it was recently announced. Doctor Jones, who graduated in 1944 from the University of Louisville School of Medicine, interned at Kansas City General Hospital. He was a general practitioner in Louisville for several years before becoming a resident at the University of Iowa School of Medicine.

Walden R. Smith, M.D., a 1946 graduate of the University of Louisville School of Medicine, has started practice at Fort Knox, it was recently announced. Doctor Smith, who six years of active service in the U.S. Army Medical Corps, completed his residency in anesthesiology at Louisville General Hospital and from 1953-54 was chief of anesthesiology at Louisville VA Hospital.



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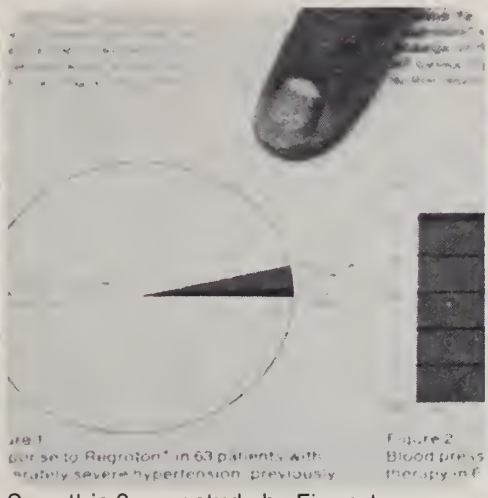
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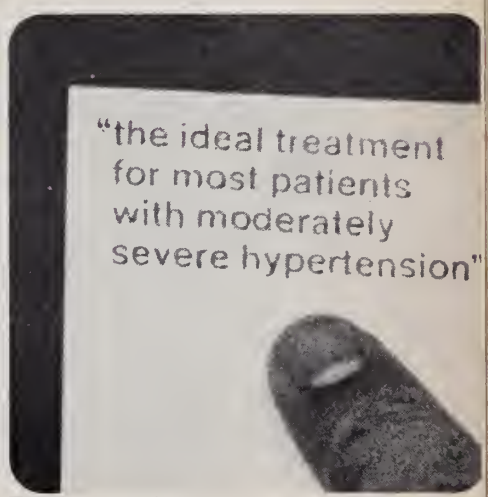
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*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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AMA House of Delegates Acts on Major Medical Issues At 18th Clinical Convention at Miami Beach

Health care for the aging, a new teletype communications system for the medical profession, a statement on human reproduction and recommendations from the Commission on the Cost of Medical Care were among the major subjects acted upon the House of Delegates at the American Medical Association's 19th Clinical Convention held November 29-December 2 in Miami Beach, Florida.

Final registration at the convention reached a total of 9,356, including 4,118 physicians.

Definitive action on the issue of health care for the aging came with the House of Delegate's strong endorsement of Dr. Ward's Monday address, in which he declared that "We have no choice except to stand firm in our efforts to prevent the standards of health care in this country from being undermined by a radical departure from the unique American way which has accomplished so much for mankind."

To implement the ideas in Dr. Ward's address, the House gave unequivocal approval of a Board of Trustees suggestion that an expanded educational program be conducted in the next few months. In asking for this approval, the Board pointed out that "a variety of techniques and media must be utilized if the public, the Congress and special audiences are to be reached effectively."

The House took no action on three resolutions which would have altered the AMA position on health care legislation. Instead, the House adopted a resolution which urged "component associations to stimulate the state and local governments to seek the fullest possible implementation of existing mechanisms, including the voluntary health insurance principle, to the end that everyone in need, regardless of age, is assured that necessary health care will be available."

The state medical societies also were urged to send representatives to two forthcoming conferences related to the issue of health for the aging—one on December 13 to help plan the new educational program and the other on January 9-10, 1965, to consider further implementation and expansion of the Kerr-Mills programs.

The House approved a recommendation from the Board of Trustees for establishment of a tele-typewriter communications service between the AMA and the state medical societies. The system will provide automatic and uninterrupted communications between AMA Headquarters and all participating state societies, and between the state societies without involving the facilities at the AMA Headquarters. The system also will enable any state society to communicate with all other TWX subscribers in the United States and Canada.

Updating its policies on population control, "to conform to changes in society and medicine" and to "take a more positive position on this very important medical-socio-economic problem," the House adopted the following four-point statement.

"1. An intelligent recognition of the problems that relate to human reproduction, including the need for population control, is more than a matter of responsible parenthood; it is a matter of responsible medical practice.

"2. The medical profession should accept a major responsibility in matters related to human reproduction as they affect the total population and the individual family.

"3. In discharging this responsibility, physicians must be prepared to provide counsel and guidance when the needs of their patients require it or refer the patients to appropriate persons.

"4. The AMA shall take the responsibility for disseminating information to physicians on all phases of human reproduction, including sexual behavior, by whatever means are appropriate."

With modifications suggested by the Board of Trustees, the House approved 33 recommendations from the Commission on the Cost of Medical Care. The suggestions had been rearranged by the Board into four sections—Research, Hospitals, Physicians and Miscellaneous. In accepting the Board report, the House also rejected a floor amendment which recommended that a medical advisory committee composed of practicing physicians be appointed to supervise the several studies which were suggested.

In presenting its conclusions and recommendations to the Board of Trustees, the Commission on the Cost of Medical Care expressed the hope "that the recommendations which are approved will help promote the wisest possible use of the medical care dollar and aid in the development of more meaningful data on the cost of medical care."

In considering a wide variety of annual reports, special and supplementary reports and resolutions, the House also:

Agreed that the AMA should cooperate with the U. S. Public Health Service in eradicating the Aedes aegypti mosquito from the American hemisphere;

Urged strong support of the Woman's Auxiliary and asked the state and county medical societies to give serious consideration to the idea of joint husband-wife membership;

Agreed that a section on Space Medicine should not be created at this time;

Emphasized its continuing awareness of the demand for action on satisfying the need for increasing numbers of family physicians;

Urged all state and component medical associations to approve, where feasible, the inclusion of a voluntary, nondeductible contribution to independent political action committees on the society's annual dues billing statement;

Agreed with the Board that there should not be an increase in AMA dues at this time;

Reaffirmed its approval and support of the National Council for Accreditation of Nursing Homes and

Instructed the Board to re-evaluate the mission of

Continued on Next Page

the Commission on Medical Practice and take appropriate action.

The American Medical Association Education and Research Foundation reported to the House that one out of every six medical students, interns and residents in the U. S. is now receiving financial assistance from the Foundation's loan fund. The AMA-ERF also announced that Merck Sharp & Dohme pharmaceutical company has made its fourth $100,000 contribution to the loan fund and has pledged an additional $100,000 in 1966.

Dr. McBeath New Hospital Head

William A. McBeath, M.D., Frankfort, director of medical services for the State Department of Health, assumed the additional duty of director of hospital and medical facilities for the Department on January 1.

Doctor McBeath succeeds Mr. Paul A. Hackney, who retired. Mr. Hackney had been with the Department of Health for 36 years.

Four Attend Hospital Meeting

J. Thomas Giannini, M.D., Louisville, was KMA's official delegate to the First National Conference on Areawide Health Facilities Planning held in Miami November 28 and 29 in conjunction with the AMA's Winter Clinical Meeting.

Attending with Doctor Giannini was George A. Sehlinger, M.D., president of the Jefferson County Medical Society. Also at the meeting were J. Ed McConnell and Avil McKinney, both of Louisville, officials of Blue Cross and Blue Shield Plans.

Ky. M.D.s Present Paper

F. Norman Vickers, M.D., assistant professor of medicine, and Thomas R. Marshall, M.D., associate professor of radiology, both of the University of Louisville School of Medicine, spoke at the annual meeting of the Radiological Society of North American in Chicago November 29-December 4. The topic of their paper was "Fiberscopic and Radiographic Correlations in Diagnosis of Gastric Lesions".

Foundation Dedicates Building

The new $2,250,000 Education Building of the Cleveland Clinic was dedicated at ceremonies late in November, with Edward R. Annis, M.D., immediate past president of the AMA, delivering the main address. The building has been described as one combining both great beauty and maximum utility.

Industrial Group to Meet Apr. 1

The Kentucky Industrial Medical Association will hold its Annual Meeting April 1, 1965 with the cooperation of the University of Kentucky College of Medicine in Lexington. Arthur J. Shulthise, M.D., Louisville, is president of the KIMA, and John E. Eckerle, M.D., is secretary.



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JANUARY

6, 13, 20, 27	"Electrocardiographic Interpretation": 7:00 p.m. - 9:00 p.m. (Wednesday evenings), University of Louisville Medical Center, Louisville
14	KAGP Northern Kentucky Seminar, Sheraton-Gibson Hotel, Cincinnati, Ohio
14	Pediatrics, "Refresher Course", 8:00 a.m.- 5:00 p.m., University of Kentucky Medical Center, Lexington
21	University Surgery Day, 12:00-5:00 p.m., University of Kentucky Medical Center, Lexington
27	KMA First Trustee District Meeting, Boswell's- Restaurant, Paducah, Kentucky
29	"Cardiology Night": 7:30 p.m. - 9:00 p.m., University of Kentucky Medical Center, Lexington

FEBRUARY

3, 10, 17, 24	"Electrocardiographic Interpretation": 7:00 p.m. - 9:00 p.m., (Wednesday evenings), University of Louisville Medical Center, Louisville
4	"Professor's Day": 9:00 a.m. - 3:00 p.m., University of Kentucky Medical Center, Lexington
10-17-24	Fourth Semiannual Postgraduate Course in Psychiatry for Practicing Physicians, University of Louisville School of Medicine, Course to be held at Louisville Area Mental Health Center, 2:00 - 6:00 p.m.*
11	Pediatrics, "Refresher Course": 8:00 a.m. - 5:00 p.m., University of Kentucky Medical Center, Lexington
18	Medicine, "G. I. Diseases": 8:00 a.m. to 5:00 p.m., University of Kentucky Medical Center, Lexington
26	"Cardiology Night": 7:30 p.m. - 9:00 p.m., University of Kentucky Medical Center, Lexington

**This postgraduate course in psychiatry will meet every Wed. for 15 weeks*

MARCH

3	"Electrocardiographic Interpretation": 7:00 p.m. - 9:00 p.m., (Wednesday evenings), University of Louisville Medical Center, Louisville
3-10-17-24-31	Fourth Semiannual Postgraduate Course in Psychiatry for Practicing Physicians, University of Louisville School of Medicine, Course to be held at Louisville Area Mental Health Center, 2:00 - 6:00 p.m.
11	Pediatrics, "Refresher Course": 8:00 a.m.- 5:00 p.m., University of Kentucky Medical Center, Lexington
11-12	Hematology, University of Kentucky Medical Center, Lexington
12-14	American Medical Association's Council on Medical Education, Stouffers' Inn, Louisville
18	KMA Interim Meeting, Gabe's Motor Inn, Owensboro, Kentucky
26	"Cardiology Night": 7:30 p.m. - 9:00 p.m., University of Kentucky Medical Center, Lexington
29-30	Symposium on Genito-Urinary Disease, University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

JANUARY

9-14	American Academy of Orthopaedic Surgeons, Americana Hotel, New York, New York
14	Northern Kentucky Seminar, KAGP, Cincinnati, Ohio
20-22	*Diabetes in Review: Clinical Conference, 1965,* Drake Hotel, Chicago, Illinois
25-27	American College of Surgeons, Sectional Meeting, Atlanta Biltmore Hotel, Atlanta, Georgia
25-27	Society of Thoracic Surgeons, Chase-Park Plaza Hotel, St. Louis
29-31	Southern Radiological Conference, Grand Hotel, Point Clear, Ala.



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Private Practitioner and the Public Health Physician

Continued on Page 37

I know of no field in medicine which offers so many varied challenges to the intelligent and capable young physician. Research, administration of research programs, general public health administration, teaching the mass of the population and the enforcing of public health prac tice—all fall within the realm of the specialist in public health. In the past few years research has yielded us techniques for the elimination of one disease after another by public health methods. Communicable diseases, nutritional diseases, mental diseases, diseases produced by toxic and radioactive substances and even diseases produced by trauma have fallen into the capable hands of the public health practitioner because these diseases have now been found to be amenable to control. The so called chronic, or degenerative diseases such as cancer, multiple sclerosis, arthritis, etc., which have long been considered to lie solely in the field of private practice, may with the increasing knowledge of epidemiology and etiological factors, be found to be entirely preventable and thus become subject to public health practice. Today prevention of these diseases is still in the research stage and almost every school of public health is establishing a Department of Gerontology or a Department of the Diseases of Aging, along with a division directed at trying to find the causes of diseases such as cancer and arthritis.

This brief review indicates that the private practitioner of medicine is concerned with the treatment of disease after it has already occurred, whereas the public health physician is ever concerned with building a fortress about weak and puny man to protect him against a hostile world. Both the public health physician and the private practitioner are fellow laborers in the fields of this earth and as such, together are truly following the commandments: "Love thy neighbor" and "Be thou thy brothers keeper".

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Philip Solomon, M.D., Chairman, A.P.A. Committee on Medical Practice, Boston, Mass.

Course will be given at Jung Hotel, 1500 Canal Street, New Orleans, La. Hotel reservations to be made directly with the Jung or hotel of your choice. Registrants who would like to enjoy Mardi Gras (March 2) are urged to make hotel reservations *immediately.*

Guest speaker for the luncheon on March 4 will be George Burch, M.D., Henderson Professor and Chairman, Dept. of Medicine, Tulane Medical School. Subject: "Emotions and Cardiovascular Disease." Cost of luncheon included in registration fee. At the end of Friday's session, there will be a dutch treat two-hour cocktail party with George Lewis and his band from Preservation Hall entertaining.

AMONG TOPICS TO BE DISCUSSED:

"Detection of Incipient Psychiatric Disorders During a General Medical Examination"
"Medical Practitioners and Supportive Handling of Schizophrenia"
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"The Physician and His Reaction to the 'Crock' "
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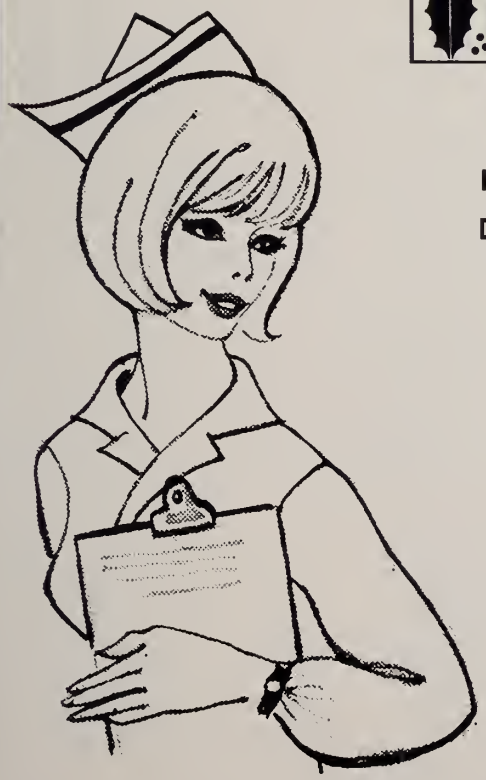
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State Mental Health Programs Get $730,000 in Grants

Two Kentucky Mental hospitals and the Kentucky Mental Health Manpower Commission have received grants totalling approximately $730,000 from the Mental Health Advisory Council of the National Institutes of Mental Health.

The grants were announced by Mr. Mike Gorman, a member of the Council, at the December 5 meeting of the Kentucky Association for Mental Health at Louisville.

Central State Hospital, Lakeland, will receive almost $300,000 over three years to improve its residential treatment service for children. Kentucky State Hospital at Danville will get $180,000 over a two-year period for a research project on the use of phenothiazines in the treatment of chronic schizophrenics. The Manpower Commission was awarded $250,000 over five years for a project on the motivation and recruitment of students into the mental health field.

History of Public Health Work Available in Journal Office

"The Medical Fraternity and the Kentucky State Board of Health, 1878-1940", a paper concerning the history of the Medical Association and the Board of Health and their relationship, is now on file in the office of The Journal of KMA, available to anyone wishing to read it.

This highly informative article, written by Broaddus B. Jackson, Ph.D., chairman of the department of history and political science at Jackson State College, Jackson, Miss., is based on material collected by Doctor Jackson for his doctoral thesis.

The complete dissertation, recently published by the State Department of Health, is entitled "A History of Public Health Administration in Kentucky, 1920-1940". The two-volume work is available in the libraries of Kentucky's two medical schools.

Noise to be Topic at Symposium

"Medico-Legal Aspects of Noise" will be the feature address presented by Aram Glorig, M.D., of the AMA Subcommittee on Noise at a symposium on Industrial Noise and Hearing Conservation in Cincinnati Thursday and Friday, February 4 and 5, 1965.

Such topics as *The Scope of the Problem, Noise Control, Hearing Conservation, Noise Measurement,* and *Hearing Testing and Conservation* are among the subjects to be considered.

W. Va. Specialty Group to Meet

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its 18th Annual Meeting at the Greenbrier Hotel, White Sulphur Springs, on April 18-21. For additional information please contact the secretary, Worthy W. McKinney, M.D., Professional Park, Beckley, W.Va.

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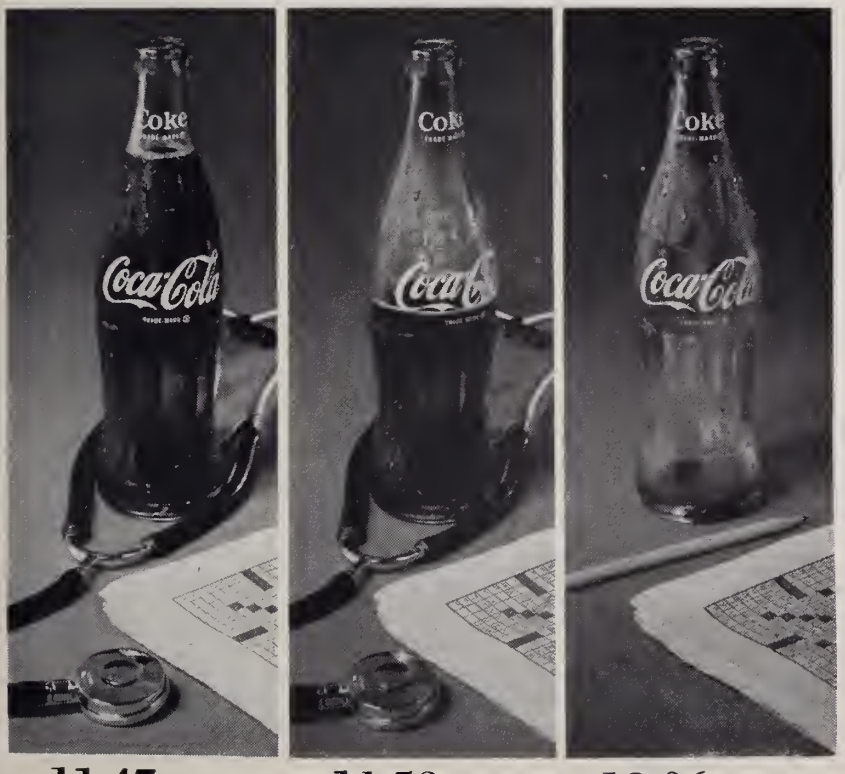
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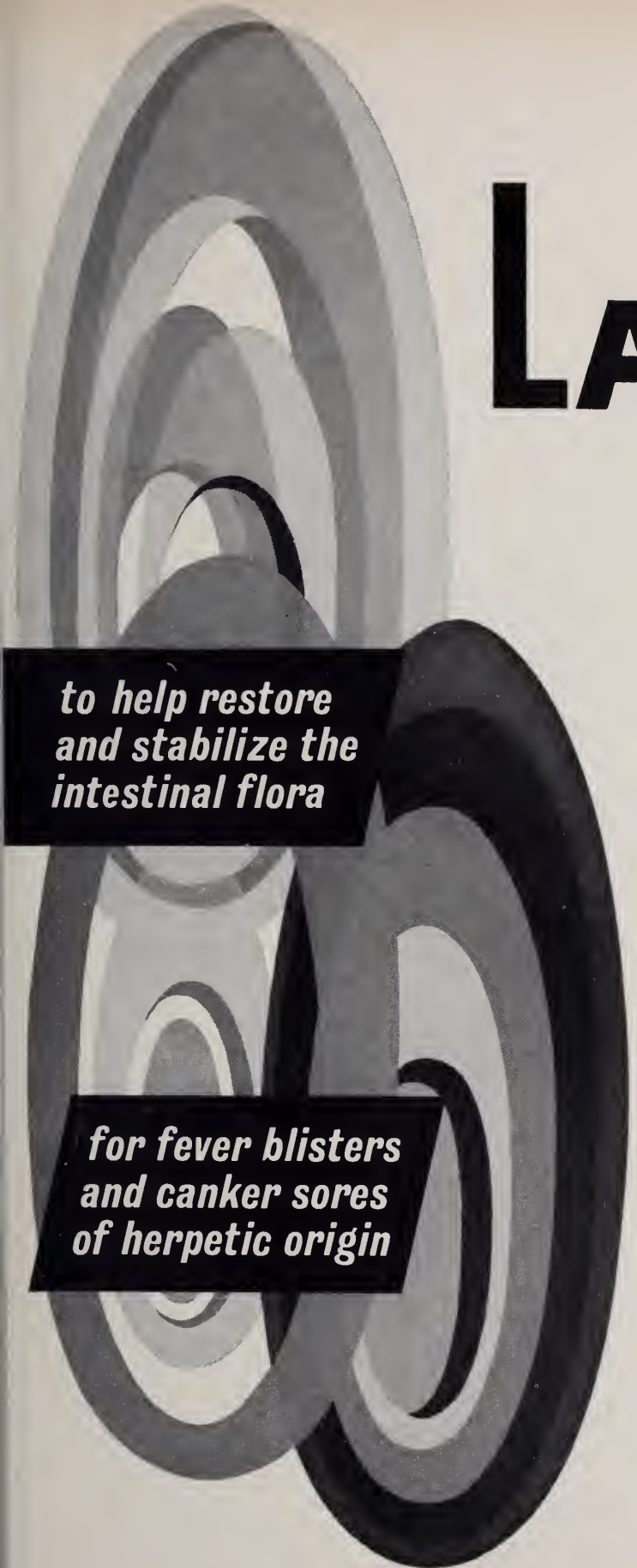
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*Roseman, E.: *Neurology* **11**:912, 1961. 33664

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(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. (2) Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. Soc., Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. State Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. 19, July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. 25, No. 12, Dec. 1963.

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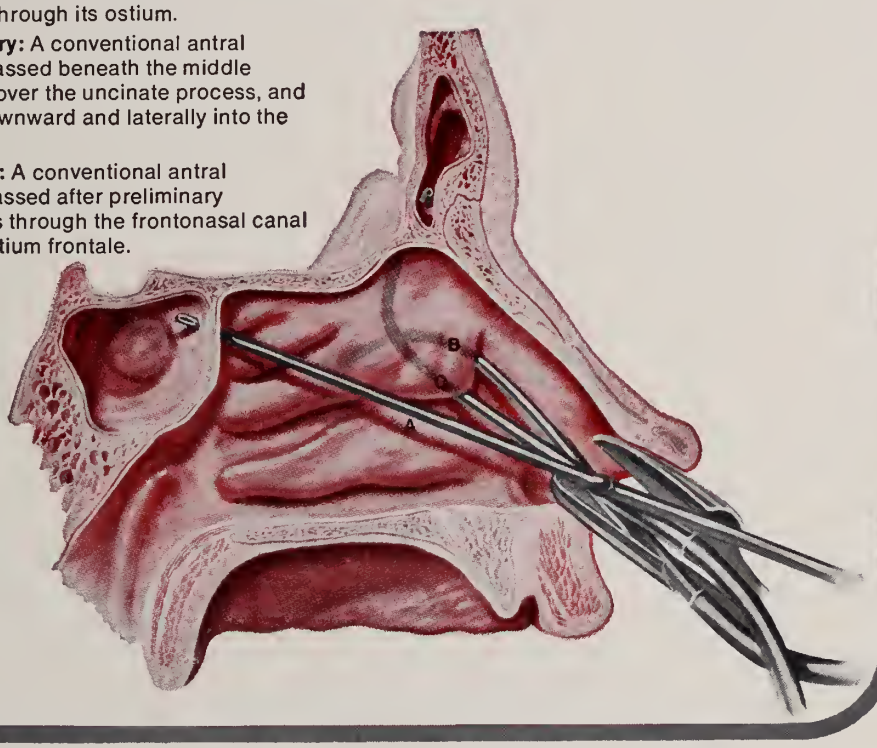
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with maximal safety from the risk of incurring codeine side effects. ● ● ● ● ● ● ● ● ● ● ● ● ● ● Contraindications: Hypersensitivity to any ingredient. Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use. Side effects: Side effects are uncommon—nausea, constipation and drowsiness have been reported. ● ● ● ● ● ● ● ● ● ● ● ● ● ● A. H. ROBINS CO., INC., RICHMOND, VIRGINIA.

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Provides the basic Phenaphen formula, plus Codeine phosphate (Warning: may be habit forming) in three strengths: ¼ gr. (Phenaphen No. 2); ½ gr. (Phenaphen No. 3); and 1 gr. (Phenaphen No. 4). Basic Phenaphen formula: Phenacetin (3 gr.) 194.0 mg.; Aspirin (2½ gr.) 162.0 mg.; Phenobarbital (¼ gr.) 16.2 mg. (Warning: may be habit forming); and Hyoscyamine sulfate 0.031 mg.

..nothing, that is, except the

sedative-antispasmodic action of DONNATAL®

Functional disturbances of gastrointestinal tone and motility present the physician with an all too common reaction to the stressful dilemmas and frustrations of modern living.[3,6]

For their dependable control, no better spasmolytic has ever been discovered than the *natural* belladonna alkaloids in combination with phenobarbital, as in DONNATAL.

Phenobarbital, as a mild sedative, has the benefit of long use and a reassuring record of freedom from unexpected and untoward reactions. In allaying subjective tension, it helps to prevent emotional stimuli from provoking or intensifying visceral spasm.

The *natural* belladonna alkaloids in DONNATAL—conforming to the classic formulation by Vollmer[5]—selectively include only the therapeutically desired alkaloids in precisely and optimally balanced ratio. The clinical uncertainties of the variable tincture and extract of belladonna are thus avoided.

Further, a recent pharmacological study has confirmed that the antispasmodic effectiveness of the belladonna alkaloids in DONNATAL is measurably potentiated by the presence of phenobarbital.[8]

Over the years, the professional consensus has reflected broad clinical confidence in the marked benefits to be achieved by DONNATAL in a wide range of visceral disorders...in peptic ulcer,[1,6] functional bowel distress,[1] gastrointestinal spasm and discomfort,[2] and other functional disturbances of visceral smooth muscle.

CONTRAINDICATIONS: Glaucoma, advanced renal or hepatic disease or hypersensitivity to any of the ingredients.

PRECAUTIONS: Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction as in prostatic hypertrophy.

SIDE EFFECTS: Blurring of vision, dry mouth, difficult urination or flushing and dryness of the skin may occur at higher dosage levels, rarely at the usual dose.

*This one at Oak Creek, Castle Rock, Arizona

References: 1. Hock, C. W.: Clin. Med. 8:1932, 1961. 2. Marks, L.: Am. J. Gastroenterol. 27:180, 1957. 3. Palmer, W. L., and Kirsner, J. B.: Therapeutics in Internal Medicine, 2nd ed., F. A. Kyser, Ed., Hoeber, New York, 1953, p. 368. 4. Ryan, J. P., Jenkins, H. J. and Robinson, S. M.: J. Pharmaceut. Sciences 53(9):1084, 1964. 5. Vollmer, H.: Arch. Neurol. & Psychiat. 43:1057, 1940. Abst. J.A.M.A. 115:333, 1940. 6. Wharton, G. K., Balfour, D. C., Jr., and Osman, K. I.: Postgrad Med. 21:406, 1957.

A.H. ROBINS CO., INC., Richmond 20, Va.

Prescribed by more physicians than any other antispasmodic —well over 5 billion doses!

Donnatal®

Robins

In each Tablet, Capsule or 5 cc. Elixir		*In each Extentab®*
0.1037 mg.	hyoscyamine sulfate	0.3111 mg.
0.0194 mg.	atropine sulfate	0.0582 mg.
0.0065 mg.	hyoscine hydrobromide	0.0195 mg.
16.2 mg. (¼ gr.)	phenobarbital (¾ gr.)	48.6 mg.

(Warning: May be habit forming.)



THE INSURANCE PAGE



Insurance Duplication

THE Health Insurance Council conservatively estimates that 11% of all policies represent duplicate coverage for people who already have one policy. Some of this is happenstance. Approximately one third of all married women are now working, and many are thus covered by employee benefit plans in addition to being eligible as their husbands' dependents. Other duplications are deliberate —some in hope of making a "profit" out of illness—others in an ill-advised attempt to secure more comprehensive coverage.

A special study group reported on this problem to the insurance industry in 1962. Approved was "the principle that over-insurance is a "moral hazard" and a potential threat to the entire health insurance industry" because of its susceptibility to abuse. The insurance companies recognized that the mechanics of policing of their claims policy would be expensive, but since the savings of "claims dollars" was *not* the prime object of the program, the decision was made to actively implement a program of enforcing non-duplication clauses.

The year 1964 was a "Tooling-up" period for those insurance companies which did not previously have "Non-duplication" clauses. Their reaction has been rapid and all indications are that 1965 will see a concerted push to rigidly enforce non-duplication clauses in group contracts.

Blue Cross-Blue Shield plans have not as yet added non-duplication clauses uniformly to all group contracts. At the present time, Kentucky Blue Cross-Blue Shield is adding such clauses to individual group contracts if the group desires it. Most employee groups, and especially nationwide groups, recognize the desirability of avoiding multiple coverage. Labor unions recognize this cost element also, but their problem is complicated by the fact that health insurance benefits are negotiated in lieu of wages. For this reason, some unions oppose these controls.

The problem of duplication in individual (non-group) contracts is more difficult to control. However, intensive investigation is in progress and mechanisms are being developed to restrict these abuses.

We have a responsibility to our patients to see that quality health care is provided at the most reasonable cost. We, therefore, should urge our patients to purchase adequate but *not excessive* coverage for illness.

WILLIAM W. HALL, M.D.



TUBERCULIN, TINE TEST

(Rosenthal) Lederle

ideally suited for routine TB screening

accurate—comparable to the older standard intradermal tests
practical—can be administered by nurses or other personnel
convenient—no refrigeration or other storage precautions
economical—stable for 2 years, self-contained disposable unit

Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis. *Available* as the new individually-capped unit, boxes of 5, or in cartons of 25.

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9635-5

Lederle

Your patients will say "The Pain Is Gone" when you prescribe

'EMPIRIN'® COMPOUND with CODEINE gr. 1/2



'EMPIRIN' COMPOUND with CODEINE gr. 1/2 (No. 3)
KEEPS THE PROMISE OF PAIN RELIEF

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



Of 425 patients with confirmed G.I. infections... 387 or 91.1% were treated successfully with Signemycin®

Note:
Loughlin and co-workers* achieved cure (absence of parasites) in all 100 of their patients with *chronic amebic colitis*. Feces became negative in all within the planned ten-day period of Signemycin administration. Upon re-examination of the feces six weeks later, the offending pathogen *(E. histolytica)* had reappeared in only 7 cases.

*Loughlin, E. H. et al.: Antibiot. Med. 7:739, Dec., 1960.

Condition	No. of Patients	No. Responded to Signemycin
Amebiasis	237	222
Cholecystitis and cholangitis	105	97
Enteritis	41	31
Peritonitis	15	14
Various, including pancreatitis, appendicitis and colitis	27	23
Totals	425	387 (91.1%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

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GIVE AND TAKE—THE DEVELOPMENT OF TISSUE TRANSPLANTATION: by Francis D. Moore, M.D.; Published by W. B. Saunders Co., Philadelphia, 1964; 182 pages, price, $5.50.

This book on the development of tissue transplantation is recommended reading for all who have any association with medicine—laymen, legislators, practitioners, or teachers. To the layman Doctor Moore offers an exciting history of how blending of knowledge in different scientific fields leads to advances in medical therapy. In contrast to the daily press, he provides a frankly realistic appraisal of the results and of the future in this field. To the legislator he demonstrates how the highest standards of medical care are achieved in a society free from regimentation and socialization by the cooperative efforts of physicians unconcerned by financial reward. The physician will be most interested in the review of scientific knowledge relating to tissue transplantation and patient selection, which provides him with the background information necessary to answer questions arising from his own practice. For those who devote their lives to academic medicine, the book not only provides a revelation of how advances are made by men who are mentally prepared, but in particular it demonstrates how one outstanding medical center has achieved its reputation by assigning promising young men to a difficult problem, and by giving them free rein and full credit. For all his readers, Doctor Moore has outlined the battle lines of the philosophical and legal problems raised on this forefront of modern medicine.

Allan M. Lansing, M.D.

CHRISTOPHER'S TEXTBOOK OF SURGERY, Eighth Edition: edited by Loyal Davis, M.D.; published by W. B. Saunders Co., Philadelphia, 1964; 1481 pages; price, $18.50.

The 8th edition of Christopher's *Textbook of Surgery* is virtually a new book. Many of its distinguished authors have revised and included new material in almost each chapter. Several chapters are rewritten by new able authors and articulate teachers. The scholarly discussion of shock by Simeone, the lucid chapter on thermal injury by Artz, the well illustrated presentation of the diseases of the pancreas by Ellison and the physiologic approach of the study of esophagus by Ellis and that of peptic ulcer by Baker and Harrison are but a few examples.

Related topics are consolidated under single authorship in this edition which provides coherence and continuity and is a distinct improvement over the previous ones. The chapter on the diseases of the breast is relatively lengthy, with over emphasis of the author's detailed scheme of management; while discussion of thyroid and parathyroid is perhaps too brief. The new chapter on the "Horizons in Surgery" by Starzl, is a timely attractive addition.

Students of surgery at all levels will find fresh and sound concepts and authoritative information in this book, and will become aware of surgery as a dynamic biologic discipline with an exciting future.

M. Atik, M.D.

DYSPLASIA, CARCINOMA IN SITU AND MICRO-INVASIVE CARCINOMA OF THE CERVIX UTERI: by Laman A. Gray, M.D., et al; published by Charles C. Thomas Co., Springfield, Ill., 1964; 438 pages; price, $22.50.

Doctor Gray has made a substantial contribution to the gynecologic literature by providing us with a book on the pre-malignant and very early invasive carcinomas of the cervix. All aspects of these diseases including cytology, pathology, biologic manifestations, ultra structure and clinical correlations are presented. Sections in Colposcopy and Colpomicroscopy are likewise included. The books ends with discussions of pregnancy in relation to epithelial abnormalities, the problems the patient faces, and an excellent summary. For those who are interested in this field it is an excellent compilation of the thoughts and beliefs of most of its recognized authorities. For the student, it presents a clear and precise definition of the entities, as well as their pathologic and clinical characteristics, and management.

The book is lavishly illustrated with excellent photomicrographs and gross pictures, which show clearly what the individual authors are discussing. Any description of the microscopic lesions would be incomplete without such graphic demonstrations. Diagrams and tables are likewise clear and concise and add to the understanding of the text.

Although the gynecologic pathologist or clinician who is a serious student of cervical abnormalities may disagree from time to time with one or another of the authors, it is important to have a book such as this in which the views of the experts are put down side by side in an easily obtainable and comparable manner. This book is a must for those interested in gynecology in general, and in early diagnosis of cervical carcinoma in particular.

John W. Roddick, Jr., M.D.



Of 748 patients with confirmed G.U. infections... 684 or 91.4% were treated successfully with Signemycin®

Note:
The efficacy of Signemycin was shown in a study of nongonococcal urethritis involving over 1600 patients.* A comparison of the cure rates of sixteen antibiotic and chemotherapeutic agents revealed that Signemycin had the highest incidence of successful response. One hundred and six patients were treated, of which 82 were followed, with cures in 70.

*Willcox, R. R. and Rosedale, N.: Brit. J. Vener. Dis. 38:19, Mar., 1962.

Condition	No. of Patients	No. Responded to Signemycin
Cystitis	29	25
Pyonephritis	30	28
Pyelocystitis	119	112
Prostatitis	14	13
Gonorrhea	66	64
Lymphogranuloma venereum	96	96
Syphilis	31	31
Urethritis, nonspecific	149	131
Various, including infections seen with impaired urinary flow or lithiasis	214	184
Totals	748	684 (91.4%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

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SIGNEMYCIN®

Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

More detailed professional information available on request.

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Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Responded To Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

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Stelazine® brand of trifluoperazine will calm your anxious working patient—with little or no drowsiness

When anxiety interferes with work, your patient needs a drug that will calm without causing undue drowsiness. With Stelazine (trifluoperazine, SK&F), you can promptly control the anxiety without producing the sedation seen with certain other agents. Anxious patients can remain active during therapy.



Stoll[1] used the drug in 50 patients with anxiety, and noted: "There was no drowsiness in this group of patients and, because of their alertness and less impaired concentration, they were able to continue with and, in some cases, return to their daily work."

Stelazine (trifluoperazine, SK&F) produces a fast therapeutic response—often within 24 to 48 hours. The convenient b.i.d. regimen frees patients from the need for a midday dose.

Principal side effects, usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness, amenorrhea and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been rare. Use with caution in patients with impaired cardiovascular systems. *Contraindicated* in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage.

Before prescribing, see SK&F Product Prescribing Information.

Photograph professionally posed.

1. Stoll, L. J.: The Use of Trifluoperazine ['Stelazine'] in General Practice, M. Press 243:578 (June 29) 1960.

SK&F **Smith Kline & French Laboratories, Philadelphia**



Your patient doesn't have to be in the Masters to get sprains and strains

Regardless of the etiology of muscle sprain or strain, 'SOMA' COMPOUND helps relieve pain and relax muscle. Patient comfort can be increased and recovery time shortened.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

rational combination therapy for sprains and strains: relaxes muscle, relieves pain. Also available with ¼ gr. codeine as 'SOMA' COMPOUND with CODEINE: carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning: may be habit-forming.)

BRIEF SUMMARY

'SOMA' COMPOUND; 'SOMA' COMPOUND plus CODEINE: carisoprodol, acetophenetidin, caffeine, codeine phosphate. *Warning: Codeine may be habit-forming.* **Indications:** 'Soma' Compound and 'Soma' Compound with Codeine are indicated for relief of pain and stiffness in traumatic, rheumatic and other similar conditions. **Contraindications:** Allergic or idiosyncratic reactions to carisoprodol or codeine. **Precautions:** *Acetophenetidin*—May damage the kidneys when used in large amounts or for long periods. *Codeine*—Should be used with caution in addiction-prone individuals. *Carisoprodol*—Like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate. **Side effects:** *Codeine*—Nausea, vomiting, constipation, and miosis. *Carisoprodol*—The only side effect reported with any frequency is drowsiness, usually on higher than recommended doses. One instance each of pancytopenia and leukopenia occurring when carisoprodol was administered with other drugs has been reported as has an instance of fixed drug eruption with carisoprodol and subsequent cross-reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. Other rarely observed reactions have included dizziness, ataxia, agitation, increase in eosinophil count, and gastrointestinal symptoms. Massive overdosage may produce coma and/or mild shock and respiratory depression. **Dosage:** 'Soma' Compound and 'Soma' Compound with Codeine, one or two tablets three times daily and at bedtime. **Supplied:** 'Soma' Compound, orange tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., and caffeine 32 mg. 'Soma' Compound with Codeine, white, lozenge-shaped tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., and codeine phosphate 16 mg. Narcotic order form required. *Before prescribing, consult package circular.*

CSO-3518

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The Surgical Treatment of Extra Cranial Cerebral Vascular Insufficiency

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The correct selection of patients with carotid arterial occlusive disease to be submitted to surgery is the key for successful results. On careful examination and evaluation more patients with subclavian steal syndrome and carotid occlusive disease are being found and corrected by surgical methods.

ARTERIOSCLEROTIC occlusive vascular disease in the great vessels of the neck and aortic arch has resulted in descriptive terms such as "pulseless disease", "carotid artery insufficiency", and "subclavian steal syndrome"[1-2]. Not all of these patients are candidates for surgical intervention. It has been found that surgical morbidity and mortality are excessive if all patients are submitted to surgery despite their cerebral state and general condition. The purpose of this paper is to present our experience at the Lexington Clinic in sixteen cases of cerebral vascular insufficiency caused by extra cranial occlusive vascular disease. All of these patients were evaluated by a team including an internist, neurosurgeon and/or neurologist, ophthalmologist and vascular surgeon.

Clinical Material

Of sixteen patients with extra cranial cerebral vascular insufficiency, fourteen were males and two females. Their ages ranged from forty-six to sixty-eight years, the average being fifty-six years.

Symptoms and Findings

All of these patients had symptoms. Half of them complained of dizzy spells, visual difficulties and transient hemiparesis. Some had a combination of these symptoms. Two of the four patients with subclavian steal syndrome had upper extremity claudication.

TABLE I

Symptoms

Dizzy spells	8
Visual difficulties	7
Transient hemiparesis	6
Speech difficulties	2
Arm claudication	2
Severe headache	1

The most common physical finding was a bruit over the involved vessel. This occurred in eleven of the sixteen patients. One half of the patients revealed arteriosclerotic retinal artery changes. Minor residual paresis and absent peripheral pulses were minimal in patients of this series. Hypertension was not found.

TABLE II

Physical Findings

Bruit	11
A-S retinal arteries	7
Minimal residual hemiparesis	2
Absent pulses	
Arm	4
Leg	0
Aortic insufficiency	1
Hypertension	0

†*Presented at the annual meeting of the Kentucky Surgical Society in Lexington May 17-18, 1963.*
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All patients were evaluated with bilateral carotid angiography. Seven patients had aortic archograms either by femoral retrograde technique or right heart catheterization. The contrast media was injected with an automatic pressure syringe. One-third of the patients showed coronary artery disease by electrocardiogram changes.

TABLE III

Diagnostic Studies

Bilateral carotid angiography	16
Aortic arch angiography	7
EKG changes suggestive of coronary heart disease	5

Treatment

Of the seventeen endarterectomies one carotid operation included a sleeve resection because of a kinked carotid artery. There was also an associated stenosing plaque. One patient in this group was explored and found to have no occlusive disease although an angiogram preoperatively showed a filling defect, which must have been an artefact. Four thoracotomies and subclavian endarterectomies were carried out for the subclavian steal syndrome. No grafts or patches were used as a significantly decreased diameter of the vessels did not occur following careful closure with 5-0 arterial silk.

TABLE IV

Operation

Carotid endarterectomy	9
staged bilateral[1]	2
+sleeve resection	1
Subclavian endarterectomy	4
Negative carotid exploration	1
Patches or grafts	0
Total procedures	17

Nine carotid endarterectomies were done under general anesthesia. Four were carried out under cervical block and local infiltration of 1% Xylocaine. Varied opinions exist regarding anesthesia in patients with occlusive disease.[3] If certain operative adjuncts were used, it was apparent that either local or general anesthetic was safe and satisfactory. All patients were heparinized just prior to cross-clamping the common carotid artery. An infusion of low molecular Dextran was used throughout the operative procedure. A Neosynephrin infusion or direct injection was used to raise the systolic blood pressure to 200-230 mm. mercury at the time of cross-clamping the carotid artery. In two patients under local anesthesia it was impossible to leave the carotid artery cross-clamped longer than five to eight seconds without the patient becoming unresponsive. By raising the pressure to the mentioned range they could then continue to carry on a conversation for an extended length of time without difficulty. If the patient could do this there was no rush to complete the endarterectomy in a set time. If the patient was under general anesthesia it was our practice to either complete the endarterectomy or re-establish blood flow in four to five minutes with the use of the plastic internal shunt. In four patients the plastic shunt was inserted just after the plaque was removed and after re-establishment of blood supply to the brain for four to five minutes the shunt was then removed and the arteriotomy site closed. If these steps are followed there is no great advantage of one anesthetic over the other. Sometimes it is quite difficult for an apprehensive patient to remain at rest on the operating table for an hour to an hour and thirty minutes, even with a considerable amount of sedation. Postoperatively six, or approximately one-third, of the patients were continued on anticoagulation therapy because of other arterial disease.

Complications

The most common complication was transient 12th nerve paresis resulting from the traction of the 12th nerve as it was removed from over the carotid bulb. All of these patients had complete 12th nerve recovery. Three ophthalmic artery emboli occurred in two patients. In one patient the embolus resulted in total artery occlusion with unilateral blindness. In one patient with bilateral carotid endarterectomies a small embolus was visualized in each eye ground. One, a refractile calcific body, was found obstructing the inferior branch of the retinal artery. The visual field defect completely compensated over a period of three to four months. The patient was not aware of having had an embolus in the opposite eye.

In this series there was no postoperative hemiparesis nor have there been any postoperative vascular deaths. One patient died eight months postoperatively with a carcinoma of the lung. A post-mortem examination revealed the patient's carotid artery that had been endarterectomized to be entirely patent.

TABLE V

Complications

Transient 12th nerve paresis	5
Ophthalmic artery emboli (late)	3
Hemiparesis	0
Deaths	0

TABLE VI

Results — 16 patients

1. No neurological symptoms	10
2. Improved-minimal symptoms	4
3. Operations that should not have been performed	
A. Total carotid occlusion	1
B. Negative exploration	1
Total	16

Results

All patients have been followed from six months to two years. Of the sixteen patients in this series, ten now have no neurological symptoms. Four have been greatly improved but continue to have minimal symptoms. Two patients should not have been operated upon, one with total carotid occlusion and the other with a negative exploration following positive angiogram. Rarely are patients with total occlusion helped by endarterectomy unless it is a fairly recent acute process. Asymptomatic patients with incidental partial occlusion and patients with obvious fixed neurological deficits have not been operated upon.

Summary

Sixteen patients with extra cranial cerebral vascular insufficiency underwent endarterectomy without mortality and minimal morbidity. General and local anesthesia are both safe provided certain precautionary steps are taken. All patients but two, who should not have been operated upon, were improved following endarterectomy. Approximately two-thirds of the patients have remained neurologically asymptomatic during their six months to two year follow-up period.

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Acute Pancreatic Pseudocyst With Spontaneous Drainage Into Descending Colon

ALBERT G. GOLDIN, M.D. F.A.C.P.,* AND HERBERT WALD, M.D.**

Louisville, Ky.

Pancreatic pseudocyst is a complication of acute pancreatitis, usually requiring surgical management. Spontaneous internal drainage of one of these cysts is a rarity, which may effect a cure when it does occur.

ONE OF the distressing sequelae of acute pancreatitis is the development of a pseudocyst. This complication arises secondary to the extravasation of pancreatic secretion which produces necrosis and bleeding in the contiguous tissues and structures. Walling off of this collection of fluid and debris is accomplished by the necrotic pancreas, blood clots and adjacent viscera, including spleen and omentum.[1] These processes produce a fibrous lined cavity, the size of which usually remains stable. Occasionally it may regress somewhat if there is a connection with the pancreatic duct, through which some of the liquefied contents may evacuate.

Management of the pseudocyst is usually a surgical problem, since spontanous resolution rarely occurs.

The following case report is of interest in that there was spontaneous drainage of a pseudocyst into the colon by way of an internal fistula.

Case Report

S.G., a 48 year old white man was admitted to Norton Memorial Infirmary on July 30, 1958, complaining of severe abdominal pain with nausea and vomiting of 8-10 hours duration. The pain developed in the peri-umbilical region shortly after lunch, gradually becoming more severe and localizing to the right side of the abdomen. There was a past history of an episode three months previously, consisting of abdominal cramping with vomiting, and some diarrhea, probably brought on by laxatives. The abdomen was soft and peristalsis hyperactive, and the process subsided in 48 hours. It was regarded as a gastroenteritis. Otherwise there were no gastrointestinal tract complaints in the past.

The patient had been seen several times in the previous three years for mild elevation of blood pressure. He did not consume alcohol.

At the admission examination, the patient was in great distress due to abdominal pain. His skin was moist and cool. The blood pressure was 110/86. The heart tones were normal but the rate was approximately 110 per minute. The lungs were clear. The abdomen was very tender to palpation throughout, most marked in the right uper and lower quadrants with rebound tenderness. The bowel sounds were absent. The serum amylase was 128 Van Loon units (normal 8-64 units) at the time of admission. The blood also exhibited hemoconcentration and leucocytosis. A 3 plus urine sugar was noted.

The course during the next 8-10 days was very stormy. His temperature ranged from 102-104 degrees rectally. Circulatory collapse developed about 48 hours after admission, requiring Levophed® for maintainance of blood pressure. Electrocardiograms showed left bundle branch block, with changes in the RS-T segments in serial tracings strongly suggesting the possibility of myocardial infarction.

On the 6th hospital day there was a sudden onset of dyspnea, cyanosis and tachycardia of 160 per minute with a spike in temperature to 106 degrees rectally. Rales were present in both bases. Portable chest X-ray showed a density above the right diaphram resembling pulmonary infarction. He responded to digitalization, oxygen and bronchoscopic aspiration.

From the departments of Medicine and Surgery, Norton Memorial Infirmary.
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FIGURE I — Barium enema, AP view. Note extravasation of barium from mid-descending colon, mesially.



FIGURE II — Barium enema, lateral view, demonstrating fistulous tract extending posteriorly and superiorly.

Serial electrocardiograms were consistent with supraventricular tachycardia.

During this time, his serum electrolytes which were abnormal on admission (Sodium 124 meq/L; Potassium 3.5 meq/L and chlorides 122 meq/L) were corrected, as was the dehydration. In addition, serum albumin was administered intravenously. Demerol, corticosteroids, anticholinergics, insulin and digitoxin were given parenterally as required. Gastric suction was maintained during this period.

By the 10th hospital day his condition was beginning to stabilize and he was more alert. At this time a mass was felt in the left upper quadrant. It was about a hand's breadth in diameter and somewhat tender, but very vague in outline.

By the 20th hospital day he was taking a bland diet and was slowly gaining in strength. His temperature was only occasionally elevated. The mass in the left upper quadrant seemed to vary slightly in size from time to time.

He was discharged to his home after 30 days' hospitalization at which time the left upper quadrant mass was vague and difficult to outline, and was not tender.

Thirty days after discharge the patient was readmitted to the hospital with a complaint of rather severe diarrhea, pain in the lower abdomen and low grade fever, of about a week's duration. Physical findings at this time were the same as at discharge, except that the mass in the left upper quadrant could no longer be felt. Short paroxysms of tachycardia were heard. These were supraventricular in origin by electrocardiography. The left bundle branch block pattern persisted.

Barium study of the colon (Figures 1 and 2) showed marked irritability and spasm at the level of the mid-descending colon. At this site, barium was noted to be extruding from the bowel lumen through a fistulous tract extending upward and posteriorly. No diverticuli were noted in the colon. This study was repeated a week later with the same findings.

On October 14, 1958, an occlusive transverse colostomy was performed to completely divert the fecal stream. At this time, the upper abdomen was explored. The pancreas was found to be almost destroyed, being replaced by loose fibrous tissue with multiple calcified areas. There was an indurated area which extended retroperitoneally from the tail of the pancreas to the descending colon, corresponding to the fistulous tract demonstrated by X-ray.

The colostomy was maintained until June 4, 1959, at which time it was closed, after two barium studies revealed no evidence of the previously seen fistulous tract.

The patient has since done very well, having had no recurrence of the pancreatitis or of the cyst or fistula. His diabetes has been controlled

with 18 units of NPH Insulin and an 1800 calorie diet. A mild tendency to diarrhea is well controlled with pancreatic enzymes in the form of Lipan®. There have been no manifestations of angina pectoris or of congestive failure despite moderate activity. His weight has stabilized at 150 pounds.

A gallbladder X-ray and serum calcium during the convalescent period were normal.

Discussion

The physiologic derangement responsible for the initiation of the process of acute pancreatitis is not clearly understood in all cases, although ductal obstructions associated with biliary tract disease and alcoholism remain incriminated in two-thirds of patients with this illness.[2] In the remaining third either vascular, metabolic, nutritional or auto-immune factors may be operative.[3]

As to the complication of pseudocyst, several recent series have been reported.[4, 5] The development of a mass in either the right, left or central portion of the upper abdomen following one or more episodes of pancreatitis is very suggestive of pseudosyst.[6]

In Murphy and Hinkamp's series,[4] 83% of 35 cases had a history of alcoholism and/or acute or chronic pancreatitis. A history of trauma was elicited in 11%. Displacement of the stomach anteriorly, best seen on the lateral view, is regarded as the most reliable X-ray diagnostic sign by these authors.

Management of the cyst is entirely a surgical problem and carried out by one of three methods. External drainage, either by means of a catheter or by marsupialization, with the former being preferred, is considered most desirable. Internal drainage by cystogastrostomy or Roux-Y cystojejunostomy is frequently carried out if feasible. The least desirable procedure, because of the technical difficulties, is resection of the cyst.

Rupture or perforation of the pseudocyst is the most common complication. An excellent review of this subject was presented by Hanna[6] in 1960. He found only 60 such cases in a review of the world literature. He noted that when the perforation occurs into the alimentary tract, a temporary or permanent cure may result. The usual viscus involved is the stomach, but the duodenum and colon have also been reported. The syndrome produced by this course of events includes pain, disappearance of the tumor, vomiting, hematemesis and melena. Barium studies may confirm the diagnosis[7], if the patient's condition allows.

Rupture into the peritoneal cavity, on the other hand, is associated with a very high mortality rate. It is accompanied by the development of symptoms of an acute abdominal emergency.

The very rapid development of the mass in the left upper quadrant, the cyst, is somewhat unusual,[8] inasmuch as these collections are ordinarily more slowly developed.

As to etiology, the absence of a history of alcohol ingestion, the normal biliary tract as evidenced by normal gallbladder X-rays and absence of history of dysfunction, and the normal serum calcium after recovery would rule out the most common precipitating factors. With the evidence for arteriosclerosis in the cardiovascular system, one might postulate a similar vascular disturbance in the pancreas which could have precipitated the illness.

The continued well being of the patient for more than four years after the spontaneous closure of the fistula following colostomy, with no recurrence, would indicate a cure of the cyst.

Summary

A case of spontaneous drainage of an acute pancreatic pseudocyst into the decending colon was presented. Pertinent references to the literature were cited.

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Non-Specific Vulvitis

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Non-Specific vulvitis is diagnosed by excluding all other causes. Treatment in a step wise manner is advocated.

TO MAKE the diagnosis of non-specific vulvitis the physician must rule out the following conditions: trichomonas, monilia, diabetes, severe urinary incontinence, leukoplakia and carcinoma of the vulva.

A satisfactory diagnosis of the first two conditions can be made on the first examination, provided the patient has not douched thoroughly within a few hours prior to the examination. Normal saline is drawn into an eye dropper, instilled into the vagina exposed with a speculum, and the mixture aspirated back into the eye dropper. One drop of this suspension is placed on each of two slides. A cover slip is placed on one slide and trichomonads can be recognized readily by their motility and the whip action of the flagella. To the other slide one drop of 10% potassium hydroxide is added which clears the slide of white blood cells and epithelial cells and permits clear visualization of the hyphae and spores of monilia. If a cottage cheese type of discharge is seen on the vaginal walls or on the vulva, a sample is lifted with a wooden applicator and mixed with one drop of 10% potassium hydroxide on a third slide. This technique more frequently demonstrates monilia than the saline suspension.

Diabetic vulvitis should not be included in the non-specific category because it is directly the result of the relationship of the female urethra to the vulva which results in urine loaded with glucose running over the labia. Many of us were taught in student and internship days that diabetic vulvitis could not be cured as long as hyperglycemia and glycosuria were present and that we were wasting our time trying to cure it. Better, it was said, to instruct the patient again and again in her diet, weight loss and insulin requirements and cajole her into following her instructions. In the diabetic clinic at the University of Louisville we have found that these old axioms are not true, and that with careful perineal hygiene diabetics completely out of control can be cured of their vulvitis.

Severe urinary incontinence either from fistula or neurogenic bladder may lead to a vulvitis, frequently accompanied by changes indistinguishable grossly from leukoplakia. Diverting the urine from the vulva by means of an indwelling Foley catheter plus routine hygiene will cure the vulvitis in a few days unless a true leukoplakia exists. Use of the catheter provides an excellent differential diagnostic procedure.

A leukoplakic area which persists after a few weeks of local treatment should be biopsied. If the biopsies are benign, I favor conservative therapy and reserve simple vulvectomy for those cases with intractible pruritis. Finally, any granulomatous or ulcerated lesion must be biopsied because of the likelihood of carcinoma. It is a tragic fact that many women with carcinoma of the vulva have been under treatment for pruritis by a physician for several months before the true diagnosis is made.

Steps in Treatment

After the above conditions have been excluded, the diagnosis of non-specific vulvitis is made. My regimen of treatment is a progressive one with most of the patients cured by the first step, some by the next step and so on until only a few patients remain uncured at the final step.

The first step is the instruction of the patient in perineal hygiene, which is the same as used in diabetic vulvitis. This is as follows:

1. Pour one quart of warm water over vulva after each urination, dry by gentle patting with clean cloth.
2. Warm soapy bath daily; "shampoo" perineum.
3. Daily douche.
4. Corn starch paste or vaseline prn.
5. When indicated by senile changes, estrogen cream nightly.

Associate professor of obstetrics and gynecology, University of Louisville School of Medicine.

If the perineal hygiene fails then the second step is to have the patient apply a cortisone cream, such as Cordran, bid.

The psychogenic aspects of non-specific vulvitis are worth bearing in mind and efforts should be made to uncover and then discuss any emotional problems. The young woman with vulvitis of recent onset is more likely to yield positive results than the older woman who has been scratching for years. One case illustrates this point: A twenty-six year old sterility patient had a beefy red, edematous vulva which failed to improve with perineal hygiene and cortisone ointment. Her husband was in graduate school and she resented having to work to support him. Discussion revealed a few minor insoluble problems. Phenobarbital, half grain t.i.d. was tried. She was cured within one week and has remained well two years.

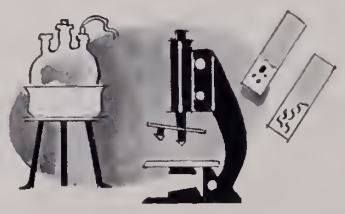
The next step that has proved of considerable value is the injection beneath the skin of an anesthetic oil, called Zyljectin (Abbott). Its composition is: Procaine base 75mgm, Butylaminobenzoate 0.30 gm, Benzyl alcohol 0.25gm, Peanut oil to make 5cc. Using a spinal needle 10cc is injected beneath the skin of each side of the vulva. As compared to the older technique of injecting alcohol into the vulva, we have found Zyljectin to be far less painful in the days following injection, much easier to administer as it can be done under local anesthesia in the office rather than under general anesthesia in the hospital. Of five patients treated with Zyljectin, three achieved excellent results, one was relieved for one year but refused a second injection when her vulvitis returned, and the fifth was a complete failure. The dramatic part of these results is that the three patients that were cured had had severe itching two, five, and six years respectively. Within one to three weeks after the injection they were completely relieved.

In a few cases nothing seems to help and finally a simple vulvectomy is done. The cure rate is excellent and the patients are exceedingly grateful. The operation is not to be undertaken lightly, however, due to the long hospitalization required and the long healing process after discharge from the hospital. The post operative pain is usually less bothersome to the patient than the pre-operative itching and burning. Important features of this procedure are: 1. the electrosurgical cutting Bovie blade which minimizes blood loss, 2. complete hemostasis by ligagtion and fulguration, 3. undermining of the vaginal mucosa and skin and relaxing incisions as needed to effect a closure as free of tension as possible, 4. postoperative use of Elase ointment (desoxyribonuclease and fibrinolysin) in the wounds to speed healing and diminish scarring.

Summary

In summary non-specific vulvitis can be managed successfully in a progressive manner:

First step:	Establish diagnosis. Perineal hygiene. Estrogen cream.
Second step:	Cortisone ointment. Psychotherapy.
Third side:	Zyljectin.
Final step:	Simple vulvectomy.



Hormone Overproduction Syndromes: Surgical Considerations

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The rapid growth in knowledge of endocrine glands has resulted in the clarification of certain diseases characterized by excess hormone production. Three of the more interesting of these diseases are summarized as to diagnosis and treatment.

SINCE Bayless and Starling established the basic concept of hormones[1] there has been a phenomenal growth of the science of endocrinology, particularly in the past decade. Somewhat parallel to this advancement has been the extension of surgery into this exciting field, producing some of the most interesting and significant gains of modern-day surgery. This is best exemplified by the vital role of surgery in those disease states resulting from an endocrine overproduction of hormones, the majority of which are well known to the practicing physician. However, some of these disorders and measures for their correction have only recently been clarified and, therefore, merit review at this time.

Insomuch as hormones are powerful chemical mediators, excess hormone production leads usually to profound changes in certain body processes. Such alterations are simply hyperfunction states and give rise to characteristic symptoms and clinical signs. This hyperfunction of endocrine tissues may result from any of the three pathological abnormalities:

1. Adenoma
2. Hypertrophy (hyperplasia)
3. Neoplasm, malignant.

These, then, are termed "functioning abnormalities" so as to distinguish them from other pathological aberrations which do not lead to excess hormone production.

The following three endocrine disorders are thought to be of enough general interest to warrant a short review of the salient facts.

Primary Hyperaldosteronism

Just eleven years ago the potent sodium retaining hormone (aldosterone) of the adrenal cortex was isolated by Simpson and others. This important work was followed three years later by Conn's fascinating description of a syndrome resulting from excess production of aldosterone with sodium retention and urinary wastage of potassium.[2] This electrolyte disturbance of marked hypopotassemia is accompanied by hypertension and a characteristic weakness. In addition, these patients have a definite polydypsia and polyuria.

Diagnosis of aldosteronism is based on the laboratory demonstration of serum potassium levels below 3.5 meq/liter. Additional laboratory findings are those of metabolic alkalosis and the specific electrocardiographic changes of hypokalemia.

The only long-term relief of this distressing syndrome results from surgical excision of the hyperfunctioning adrenal cortical tissue. The following points are of paramount importance for successful surgery:

A. The syndrome of primary aldosteronism may be due to single or multiple adenomas of one or both adrenals.

B. Vigorous attempts preoperatively to elevate the serum potassium are important to the success of the operation. If oral potassium therapy is not successful in

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elevation of serum potassium, then the use of the aldosterone antagonist spirolactone may be of value.

C. For complete exploration of both adrenals, an adequate transverse upper abdominal incision is necessary.

D. If a single palpable tumor is present, then simple removal of the tumor is the procedure of choice. If multiple tumors are present, then enough adrenal tissue must be resected to insure removal of all tumors. However, if there are no palpable tumors the safest maneuver is total resection of one adrenal gland and subtotal removal of the remaining gland.

E. Precise management of hypotension during surgery is effected by use of mineralcorticoids and vaso-constrictor agents.

F. The postoperative maintenance of these cases demands administration of cortisone and mineral corticoids in addition to usual routine.

To date, a sizable number of dramatic cures have been reported from clinics throughout the world. Interestingly enough, there have been, to my knowledge, only two cases in this metropolitan area over the past two years, both of whom underwent surgical relief of the aldosteronism.

Ulcerogenic Tumors of The Pancreas

Though it has long been known that the pancreas plays some role in the formation of peptic ulcers, it remained for Zollinger and Ellison in 1955 to describe islet cell tumors of the pancreas with a most severe ulcer diathesis resulting in the now well-known syndrome of 'ulcerogenic tumor of the pancreas.[3]' These patients present with intractable and atypical peptic ulcerations of the duodenum or upper jejunum. Characteristically, they have an excessive secretion of gastric fluid and usually a significant diarrhea. The lesions described by Zollinger and Ellison are non-insulin producing islet cell tumors of the pancreas.

The underlying mechanism for the gastric hypersecretion and ulcer diathesis was assumed to be due to hormonal influence. Evidence to support this assumption was suplied by Gregory who extracted a gastrin-like substance from the pancreatic islet tumor of a patient.[4] Injected into experimental animals, it was shown to be a strong secretogogue for the stomach. This work has been duplicated by others, and even metastatic lesions from pancreatic tumors have demonstrated substances with gastrin-like activity.

For many years surgeons have wondered why certain peptic ulcers seemed peculiarly recalcitrant, with a tendency to recur, after seemingly adequate surgical treatment. The popular opinion is that these fulminating recurrent peptic ulcers are most likely instances of functioning pancreatic adenomas resulting in the Zollinger-Ellison syndrome.

These pancreatic lesions may be either a solitary adenoma or diffuse multiple adenomas. They may occur at any site within the pancreas or may be found in aberrant pancreatic tissue in the duodenum and surrounding areas. Approximately fifty per cent of all recorded cases were due to a malignant pancreatic tumor, and a number of "functioning" metastatic lesions have been reported.

More than one hundred proved cases have served to focus the attention of surgeons on this most unusual disease, with the inescapable conclusion that vagotomy and subtotal gastrectomy do not control the ulcer diathesis in these patients. Proper surgical management is based on meticulous exploration of the pancreas (and duodenum) for "functioning" tumors or adenomas. The following general rules govern the course of action of the surgeon at the time of exploration:

A. If there is no palpable tumor, then distal pancreatectomy (in hopes of removing the source of hormone) and vagotomy is recommended. Recurrence of ulceration after this operation warrants an aggressive approach with removal of the entire stomach.

B. When there is a palpable tumor, the surgeon removes that portion of the pancreas. Again, if the syndrome recurrs, the wisest decision is to carry out total gastrectomy.

Management of the total gastrectomy patient is much simpler than the care of the complicated problems presented by the patient without the pancreas. It is because of this that Zollinger and his associates have consistently recommended total gastrectomy in preference to total pancreatectomy in those cases when there are either diffuse adenomas or the "functioning" tumor or adenoma cannot be localized. The secondary megaloblastic anemias that occur in the total gastrectomy patients have been con-

trolled by Vitamin B_{12} therapy.

There has been only one verified case of Zollinger-Ellison syndrome in this area, and this fascinating case had a large functioning metastatic islet cell tumor of the liver.[5] It is certainly likely that, as physicians become more familiar with this unusual disease, additional cases will be found in the near future. In short, all recurrent ulcer cases following standard measures must be viewed with suspicion as possibly secondary to pancreatic adenoma or tumor.

Multiple Endocrine Adenoma Syndrome

As there are relative complex interrelations between the pituitary and all other endocrine organs, it is most interesting to consider that there may well be some interrelationships between adenomas or tumors of the various endocrine organs It is for this reason that I briefly review this concept and its application, if any, to surgery.

Underdahl, Wollner, and Black in 1953 called attention to the occurrence of adenomas of more than one endocrine gland in the same patient.[6] These cases were characterized by hyperfunction of the involved gland and, as such, could be considered to be "functioning" tumors or adenomas of more than one endocrine gland, have been accumulated. It now seems that there is a definite syndrome, which for the lack of a better name, has been variously labeled multiple endocrine adenoma syndrome and endocrine adenomatosis. Most of these cases have been characterized by "functioning" adenomas of two or more endocrine glands and most often the parathyroid, pancreas, and pituitary are involved. However, the thyroid and the adrenals have been included in the reports, although apparently not as frequently as the above named glands. On several occasions members of the same family have been found to have multiple gland involvement by tumor. There has been no functional etiological relationship proved in any of the cases, but it is thought that the co-existence of adenomas in various endocrine glands may be related to some genetic influence. The involved glands may contain a single adenoma or, as frequently happens, the gland shows a picture of diffuse adenomatosis.

Surgeons are interested in this aspect of endocrinology because removal of various endocrine adenomas may be complicated by hyperfunction states as a consequence of unrecognized adenomas in other endocrine glands. Some of these complications that might occur during the postoperative period would be renal calculi, hypertension, thyrotoxicosis and hypoglycemic shock, all manifesting some functioning abnormality of an endocrine gland. For years the frequent association of peptic ulcers with hyperparathyroidism has been of interest to clinicians. It may well be that some of these ulcers are secondary to pancreatic tumor and the proper treatment of any ulcer complication following parathyroidectomy would demand careful exploration of the pancreas.

Summary

At the risk of oversimplifying these very complex hormone overproduction abnormalities, a summary of some of the more salient surgical features has been presented. The expanding field of endocrinology and its bearing upon all aspects of surgery makes it imperative that surgeons as well as physicians be cognizant of such unusual endocrine derangements.

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Anastamosis of Digital Vessels

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The past ten years have brought numerous advances in vascular surgery. The most recent are in the field of small vessel anastomosis. This paper presents a successful attempt of digital vessel anastomosis.

THE importance of vascular trauma has become progressively more apparent during the past ten years because of the successful attempts at surgical revascularization of non-viable tissues (i.e. tissues deprived of their blood supply because of trauma).[3, 10, 11, 12, 15]

Most surgeons have been faced with the amputated or nearly amputated digit. In these cases, he is expected by the patient to miraculously save the severed finger. Neither the patient nor his relatives are easily convinced that the replaced digit will not survive. In most instances of devascularized digits the referring physician and the industrial physician favor amputation because of the time and expense wasted in what they believe will be a futile atempt at salvage. A familiar scene in our General Hospital Emergency Room is that of a bleeding patient anxiously desiring reimplantation of a dismembered anatomic part. To our knowledge, the occasion of reimplanting a human finger or similar part that has been completely amputated, has never been successful.

The surgical literature contains a number of excellent papers dealing with the management of vascular trauma, but reports of small (less than 3 mm.) vessel surgery are infrequent.[1, 5, 14, 15, 16] It is not surprising that operative restoration of vessel continuity is considered for wounds above the wrist.[4, 12, 15, 17]

The prodigious work of Jacobson and Suarez has led the way in the field of microvascular surgery.[7, 8, 9] The indications thus far for this type of minute vessel surgery have been coronary artery thromboendarterectomy, endarterectomy of the small vessels of the brain, organ transplantation, and ureteral reconstruction.[6, 7, 8, 9, 13] The principal interest of our research was toward the successful reimplantation of the amputated small portion of an extremity by anastomosis of the minute blood vessels involved. The problems are many. Anyone who has attempted to open, close and maintain patency of a vessel measuring less than 3mm. in diameter, is no stranger to frustration. The method used is not original, but an additional attempt at the application of the technique developed by Jacobson and Suarez.[6, 7, 8, 9]



FIGURE 1. X-rays of partially amputated thumb. Fracture extended into metacarpal phalangeal joint.

Case Report

On 12 November 1962, P.A., a 52 year old male had his left thumb almost crushed off by a metal roller press. (Figure 1) Approximately one and one-half hours after the injury, definitive therapy was started.

Initial examination found the left hand and forearm to be covered with dirt and grease. The left thumb remained attached by two dorsal veins and threads of subcutaneous tissue. Adequate anesthesia was obtained by axillary block without improvement in the appearance of the thumb distal to the wound. The nail bed was pale and did not fill.

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FIGURE 2. Photographs 25 days after injury demonstrates healing of circular lacerations and viability of thumb.



FIGURE 3. See Figure 2 for explanation.
(Fig. 2 & 3 courtesy of Clinical Orthopaedics No. 29: 29-38, 1963.)

During the operative preparation, the tourniquet was elevated, and as soon as the technical portion of the operative procedure was started, the tourniquet was released. The hand soon developed a hyperemic flush. The thumb distal to the wound remained white in color, had no blood supply and demonstrated no retrograde bleeding. A crushing circular laceration extended completely around the base of the thumb. The proximal phalanx exhibited a severe compound comminuted, extremely unstable fracture. The extensor tendon was lacerated; the flexor pollicis longus was lacerated, as were both neurovascular bundles. Only the lacerated artery on the ulnar aspect of the thumb was in condition to repair. It was cannulized with a 27 gauge needle and flushed with heparin solution (5000 units per 100 cc of saline). The distal vascular system was opened and the irrigating solution returned through the distal open veins. Following stabilization of the fracture fragments by periosteal sutures, a small padded Kapp-Beck bulldog clamp was applied to the proximal digital artery. Jacobson spring scissors were used to trim adventitia.[6, 7, 8, 9] The artery was repaired with 9-0 arterial silk sutures (.001 inch in diameter). Two sutures were placed at equidistant points in the circumference of the vessel and the repair was then accomplished with 6 continuous over and over sutures on each side of the stay sutures. The spring handle needle holder minimizes tearing the vessel wall as the anastomosis is performed.[6, 7, 8, 9] No magnification was employed for the repair. Magnification, if available, is recomended for more accurate suture placement. Following arteriorrhaphy, the vascular clamp was released. The thumb became somewhat pink in color and the digital artery distal to the repair began to pulsate. Lidocaine hydrochloride 1% was then sprayed on the artery and the thumb rapidly improved, becoming pink, warm, and with capillary filling of the nail bed. The extensor tendon, digital nerves, and skin lacerations were repaired. At the conclusion of the procedure, the thumb was the same color as the other fingers. At 25 days post injury, the fracture was unstable. Figures 2 and 3 demonstrate healing of the soft tissue.

Discussion

The primary objectives are: (1). A minimum time lapse between injury and surgical repair. (2). Adequate visualization and magnification of the surgical field. (3). Meticulous technique utilizing an extremely fine vascular suture with the most atraumatic needle possible (anticoagulants are no substitute for meticulous technique.) (4). Minimizing thrombosis from other causes such as "kinking" of vessels.

Engler believes that even with improved suture techniques, such factors as coagulability of the blood, physiological function of the endothelium, trauma to the endothelium, release of thromboplastin and other powerful clotting accelerators from the damaged vessel, and the physiological function of the blood in stopping leaks through the suture line must be controlled in order to have successful patent anastomosis of small blood vessels.[2] This is in contrast to Jacobson who believes that the patency rate is dependent upon good suture technique.[6, 7, 8, 9]

Although an everting type of suture might seem preferable in most vascular surgery, approximating intima to intima, the narrowing

of the vessel lumen produced by such a method unfavorably influences its satisfactory use in arteries of this small caliber. Adequate venous return is as important as arterial flow. If venous insufficiency is present, veins in addition to arteries are repaired.

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Acute Renal Insufficiency Without Oliguria

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A presentation of the diagnostic and therapeutic methods of value in acute renal insufficiency without oliguria.

OLIGURIA or anuria is usually the first indication of acute renal insufficiency. However, when renal dysfunction is not associated with such startling evidence the renal damage may indeed approach irreversible proportions. We will discuss renal dysfunction in the absence of marked oliguria, its diagnosis, therapy and prophylaxis.

Renal function depends on adequate glomerular blood flow, ultrafiltration and normal tubular function. The cessation of glomerular ultrafiltration or the appearance of tubular obstruction results in total anuria. However, if glomerular ultra-filtration is normal or even reduced and alteration in the tubular reabsorptive mechanism occurs, the urine volume may be maintained without noticeable change. In this situation a diminished excretion of urinary solids results in a progressive azotemia and electrolyte imbalance. The progressively disturbed electrolyte pattern produces a toxic effects varying from gastro-intestinal disturbances to mental confusion to death due to cardiac ventricular fibrillation associated with uremic hyperkalemia.

Secondary Dysfunction

In contrast to primary renal dysfunction secondary extra-renal disturbances may alter electrolytes which in turn induce renal tubular malfunction and renal insufficiency which is masked by normal urine volume. The disturbed tubular mechanism fails to eliminate enough urinary solids and thus progressive azotemia and ever compounding secondary electrolyte imbalance may proceed to serious, if not fatal, proportions.

First, let us consider a large group of patients with normal renal function who may easily get into serious renal and electrolyte problems. These are infants and very young children. This problem is occasioned by their normally high metabolic rate which is at least twice that of the adult and therefore requires a much greater fluid intake to prevent azotemia and associated electrolyte imbalance. This is particularly important in infants for their tubular reabsorptive mechanism has not developed and they are unable to appreciably concentrate urine. One must be ever cognizant of these basic physiological facts, particularly during acute febrile illnesses and postoperatively.

In adults, prolonged diuresis may gradually lead to unrecognized dehydration with its associated electrolyte imbalance and concomitant progressive renal insufficiency without obvious early reduction in urine output. An example of this was seen in an elderly patient who continued his diuretic over a protracted period and was found by his daughter to be mentally confused and dehydrated. Fluids were forced without improvement, in spite of a satisfactory urine output. On admission to the hospital, the patient was alternately confused and comatose. Azotemia was marked, with an associated hyponatremia and hypokalemia.[6] Dehydration was severe. The continuation of fluids without sodium and potassium would certainly have proved fatal. However, hydration and the correction of the plasma sodium and potassium provided immediate response with rationality and a feeling of well being within forty eight hours and a normal urea nitrogen within four days. In this particular problem sodium replacement is as life saving as it is in an Addisonian crisis or heat exhaustion.[5]

In protracted vomiting or prolonged gastric suction hypochloremic alkalosis is possible. Metablic alkalosis is more harmful to the kidney than acidosis and patients with pre-existing renal disease are particulary vulnerable to acute renal deterioration.

Subjectively this condition may be manifest by muscle cramps, particularly of the calf muscles, probably secondary to hypochloremia. In addition to a high CO_2 combing power of the blood, there occurs hypochloremia. The potassium may be normal or depressed.

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It is mandatory in these patients to replace chloride as it is lost and be aware of any changes in the serum potassium.

In contradistinction to hypochloremic alkalosis there may occur, with protracted ammonium chloride medication, hyperchloremic acidosis. This is occasioned by the inability of the renal tubules to form sufficient ammonium cation to pair with the excessive chloride ions and thus salt is lost with a resultant acute renal insufficiency.

The clinical picture of hyperchloremic acidosis is hyperventilation, Kussmaul breathing, lethargy, progressive oliguria and eventual coma. Biochemically there occurs a low CO_2 combining power, hyperchloremia and a low or normal sodium. Therapeutically there is a prompt response to alkaline medication administered orally or intravenously as is dictated by the condition of the patient. An intravenous preparation which provides an appreciable measure of safety from over alkalinization is 1/6 M. sodium lactate solution.

Obstructive and Other Uropathies

On occasion, in obstructive uropathies there occurs an un-noticed acute renal dysfunction with progressive and even fatal uremia with seemingly adequate or even large urine volumes. The precise pathological process is not fully understood, but the primary failure concerns tubular reabsorption. The urine is so dilute that the necessary urinary solids are not excreted. In the presence of an essentially normal electrolyte study these patients respond to exceedingly large fluid intake to literally flush out the necessary urinary solids by mere dilution.

It is important to realize that a patient unable to concentrate the urine to more than 1.012 will require at least 2000 ml. urine output to remove the necessary 35 grams of urinary solids per day whereas the normal kidney can accomplish this with but 500 ml. of urine.

The relationship of central nervous system disturbances to renal dysfunction is not generally appreciated.[8] The precise mechanism of this process is not clearly understood, but probably involves disturbance of the osmo-receptors and and volume receptors. Biochemically the serum changes include hypernatremia, hyperchloremia, and hypotassemia with severe azotemia. The urine volume is not disturbed and occasionally is seemingly excessive in spite of progressive and alarming azotemia.

Probably the most common occurence of acute renal failure without noticeable oliguria is in the coma associated with diabetes mellitus. In this situation the correction of fluid balance and the carbohydrate metabolism returns renal function to its inital state.

Acute Insufficiency

Acute renal insufficiency in surgical, postoperative, obstetrical and fulminant infections is unquestionably the most serious problem that we encounter and unless immediate corrective steps are taken irreversible renal failure often results. In this group of patients systemic arterial hypotension with initial inadequate glomerular blood flow is the causative factor. It is important to realize that clinically measurable arterial hypotension may not reflect the degree, extent, nor duration of functional hypotension in the glomerulus.[3] Thus, ultrafiltration may cease or be measurable reduced for periods which exceed the recorded duration of arterial hypotension. Hence, prophylactic measures for maintaining ultrafiltration are essential in the prevention of acute renal insufficiency and its potentially disastrous tubulonecrosis.

Intravenous mannital is most efficacious in preserving glomerular blood flow and preventing tubulonecrosis. Mannitol leaves the vascular bed slowly and passes through the glomerular membrane freely to enter the tubular lumen. In its passage through the tubular lumen, mannitol by virtue of its osmotic characteristics holds water within the tubule, discourages the reabsorption of urea and minimizes cellular edema, which prevents cast formation, tubular obstruction and eventual tubulonecrosis.[2]

There is in essence a dual approach to the conservative management of acute renal insufficiency. First, by initiating therapy in anticipation of the possible occurence of insufficiency and second, immediate therapy at the onset of renal insufficiency or even better upon discovery of severe systemic arterial hypotension.

A method for the prevention of possible acute renal failure[7] is outlined in the following plan:

The day preceding surgery a complete electrolyte panel should be obtained, including blood urea nitrogen and creatinine. One hour before the administration of anesthesia the patient is given hypotonic saline intravenously (1

part normal saline and 2 parts of 5 per cent glucose in distilled water) in an amount equal to 10 ml./kg. body weight plus the amount of the over night urine. Just prior to surgery an osmotic diuresis is induced by administering 25 grams of mannitol in a period of 8 to 10 minutes and is continued by giving sufficient 20 per cent mannitol intravenously to provide 1 to 3 ml./minute urine flow throughout the operative period. The mannitol infusion is continued for 24 hours following surgery. During the first 24 hours post-operative period one or more electrolyte panels and urea nitrogen studies are obtained. If urine volume is satisfactory and the blood studies favorable the mannitol may be discontinued and the usual fluids continued for adequate hydration.

A procedure to be employed when an acute renal insufficiency develops or in the event of unanticipated arterial hypotension is the following:

A 12.5 gm. loading dose of mannitol is given intravenously in a 25 per cent solution during a 3 minute period.[2] If there is no increase in the urine flow within three hours the usual method of avoiding over-hydration during acute renal insufficiency must be rigidly observed. However, if an increase in urine flow occurs which is not beyond 40 ml./hr. a second test dose is administered. On the other hand, if the urine output exceeds 40 ml./hr. a 25 per cent mannitol solution is continued intravenously at a rate to maintain a 100 ml./hr. urine flow and the total dose of 100 Gm. of mannitol per 24 hours is not exceeded. This method is extremely valuable particularly in unexpected systemic arterial hypotension before acute renal insufficiency is established.

Summary

The problem of acute renal insufficiency in the absence of marked oliguria is discussed and various entities described. The method of dealing with anticipated acute renal insufficiency is described as well as the initial steps to be taken when renal failure is first discovered to minimize cellular deterioration, prolonged morbidity and possible mortality.

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CASE DISCUSSIONS
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The Case of the Tremulous Man
Addiction to Sedatives and Hypnotics

Hugh A. Storrow, M.D.*

"WHEN I was in that hospital, I really blew my stack." The balding man with the weathered skin didn't really want to talk. He was too restless. He couldn't sit still. He tapped out a rhythm on the desk with his fingers, crossed and recrossed his legs, and picked at his ear lobe. When I asked him to hold his hands out in front of him, his fingers trembled.

"I'd like to hear a little more about that," I said.

"I guess it was about six months ago now. I was in there for an operation. Couldn't stay in bed. Got up and ran around the room. I thought I saw some big bugs come in. Thought they were going to sting me."

"Were you nervous before you went into the hospital?"

"Lord, yes. That's been going on for ten years, I guess. I've been getting some help lately from those white tablets. Doriden, I think they are. They don't help as much as they used to, though. Took Miltown for awhile, and that helped some. I used to think whisky was the best, but I haven't had any of that for six months. Doctor's orders."

The "nervousness" Mr. Mitchell** referred to was a recurrent pattern of anxiety and depression. Two previous courses of electroconvulsive treatments had produced remissions. As is usual in such cases, there had been a subsequent recurrence each time.

Inquiring carefully into the history of sedative intake, I learned that Mr. Mitchell had been taking three ½ gm glutethimide (Doriden®) tablets each day and two more at bedtime for over a year. This daily intake of 2.5 gm reduced his feelings of tension and helped him to sleep, although its effectiveness was apparently decreasing. Since he had stopped his Doriden abruptly at the time of the hospitalization for surgery, the reaction he described was apparently a psychosis associated with withdrawal.

His last dose of Doriden had been about four hours before I saw him. When he arrived in the emergency room he was beginning to show early abstinence signs such as tremulousness, anorexia, and sweating. He also complained of insomnia which was later confirmed by ward observation.

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** The patient's name is fictional.

Tolerance and addiction to glutethimide have been suggested as beginning at a chronic dosage level of 2.5 gm per day.[1] Since there was a past episode of delirium possibly due to glutethimide withdrawal and since Mr. Mitchell was already showing early signs of abstinence, I decided to consider him addicted and to use the withdrawal program outlined below. The presumptive diagnosis of glutethimide addiction was confirmed by the fact that 800 mg of pentobarbital per day was initially required to block abstinence signs. Following withdrawal, Mr. Mitchell's anxiety and depression were managed with moderate success by a short course of electroconvulsive treatments. He is likely, however, to suffer recurrences of these symptoms in the future. He will always be an addiction risk if sedatives are used to control his anxiety.

The problem of addiction to sedative medication is apparently increasing in scope. During the past year we have seen five cases on a 14-bed psychiatric ward. Two patients were addicted to barbiturates and two to glutethimide (Doriden®). One was taking both a barbiturate and diazepam (Vallium®). Cases can probably be picked up in almost any field of medical practice if the diagnosis is seriously considered.

Prophylaxis

The barbiturates have long been known as dangerous drugs. In intoxicating dosages they impair judgment and can cause accidents. Their importance as suicidal agents is also well known. Patients who take these drugs over long periods of time develop tolerance and are likely to exceed prescribed dosages. When substantial amounts are taken over extended time periods, sudden withdrawal can lead to delirium, convulsions, and even death.[2]

Recently, we have begun to note the same problems with so-called "non-barbiturate sedatives" and with certain similar drugs described as "tranquilizers" or "relaxants." Some of the agents which can cause difficulties are: meprobamate (Miltown®, Equanil®), glutethimide (Doriden®), ethchlorvynol (Placidyl®), methyprylon (Noludar®), and chlordiazepoxide (Librium®). Diazepam (Vallium®) may be associated with similar problems. If so, its relatively

long period of action may complicate withdrawal.

Be careful in prescribing these drugs for chronic conditions. Avoid refillable prescriptions. Remember that patients can go to other physicians without telling them they've seen you. Be particularly cautious with alcoholics, chronic neurotics, and patients with personality disorders. These patients are likely to be addiction-prone.

Treatment

Be suspicious! Whenever a patient comes in with anxiety, tension or agitation, be sure to take a careful history of drug intake. If you're not certain that a patient is taking enough to be addicted, be conservative and decide that he is. A barbiturate test dose or two will quickly and safely settle the issue. One of my patients was a prim little lady who was too embarrassed to tell me that she was taking large quantities of glutethimide. She "split the difference" and told me she was taking half of what she was actually taking!

Another point to remember is that acute intoxication can occur in the presence of addiction.[1] Patients treated for sedative overdosage can suffer an abstinence reaction as the medication effect wears off. A high index of suspicion coupled with careful observation can prevent such embarrassing and dangerous situations.

The severity of the sedative abstinence syndrome is a function of the dose and probably also of the length of time the patient has been at this dose level.[3, 4] In the case of pentobarbital the minimal addictive dose is probably more than 0.4 gm daily. In the case of amobarbital more than 0.8 gm daily is probably required.[3] The minimal addictive doses for some of the newer sedative and tranquilizing drugs have not been accurately determined. In the case of meprobamate (Miltown, Equanil), the minimal addictive dose is probably more than 1600 mg per day, and perhaps, more than 2400 mg daily. For glutethimide (Doriden) 2.5 gm per day may be sufficient to produce addiction. Carl Essig has discussed the probable minimal addicting doses for a number of commonly used non-barbiturate sedatives and tranquilizers.[1] The phenothiazines and the Rauwolfia alkaloids apparently do not have a clinically significant addiction liability in man.[4]

When you suspect addiction, check repeatedly for abstinence signs. These usually appear during the first 24 hours following the last drug dose. Look for tremulousness, anxiety, insomnia, anorexia, profuse sweating, and postural hypotension. The later and more dangerous signs appear two to four days after the last dose. These are convulsions and/or a delirious episode characterized by agitation and hallucinations which are usually visual.[4] The typical signs and symptoms of abstinence from sedative medication should not be confused with the rather different picture which characterizes narcotic abstinence. The narcotic abstinence syndrome is also treated differently.

A good history of drug intake is a major help in diagnosing abstinence. The history may not be trustworthy, however, and major attention should be given to the signs and symptoms. The EEG may be helpful in diagnosing questionable cases. The characteristic findings in barbiturate intoxication are a mixture of low voltage rhythmic fast activity and slowed alpha rhythms. During withdrawal, paroxysmal discharges appear before seizures and can be found even in patients who escape convulsions.[4]

When a presumptive diagnosis of abstinence has been made, we use the procedure recommended by Wikler.[4] This approach is based on the fact that barbiturates will block the abstinence syndrome due to any of the drugs mentioned here. Pentobarbital is used to control the signs and symptoms of abstinence, and this drug is then gradually withdrawn. The relatively short action of pentobarbital is advantageous since it enables the course of withdrawal to be closely followed. A "test dose" of 200 mg of pentobarbital is given orally, and the patient is observed one hour later for signs of mild barbiturate intoxication: slight dysarthria, swaying on the Romberg, slow inconstant nystagmus on lateral gaze, and drowsiness. Signs of more severe barbiturate intoxication after the first test dose—marked dysarthria, inability to do the Romberg at all, and fast nystagmus—suggest that the patient has little tolerance and no dependence on hypnotic drugs. Repeated 200 mg test doses of pentobarbital are given each hour until signs of mild intoxication appear. At this point the total dosage necessary to produce mild intoxication is computed, and the patient is given this amount orally every six hours. In our experience a total 24 hour pentobarbital dose of 1 gm or less has been sufficient to control abstinence signs in all patients. Larger doses should rarely be necessary. After the patient is stabilized for two or three days, the dosage is progressively reduced at a rate not more than 100 mg daily. If signs of abstinence reappear, the schedule of reduction is delayed.

Anticonvulsants such as diphenylhydantoin (Dilantin®) are ineffective in managing sedative withdrawal. Phenothiazines are also ineffective and may even be contraindicated because of their convulsant and hypotensive actions.[1]

The syndrome of barbiturate abstinence has been well known for some years.[3] It is not, however, as well known as it should be. A number of the newer sedative drugs are equally dangerous in many ways.

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SPECIAL ARTICLES

Development of Ophthalmology in the University of Louisville

Part II*

The Research Division

C. Dwight Townes, M.D., and Arthur H. Keeney, M.D.

Louisville, Ky.

SIGNIFICANT efforts at animal, laboratory, or basic investigations in ophthalmology at the University of Louisville date from the early 1950's. These projects were "window ledge operations" in the former dormitory, Moorman House, the corner of the histology lab, or in Speed School facilities.

During this period, about a dozen investigative projects were completed and published by faculty members and research fellows (F.D. Barlow, H. A. Zaki, M. V. Mody, H. L. Duerson, M. Jain, J. A. Stobbe). Two physicians earned advanced degrees, one M.S. and one D.Sc.), and an American Ophthalmological Society thesis was accepted. In 1957 Roderick Macdonald, Jr., M.D., came from Tulane to be the first full-time ophthalmologist. From a numerical low in 1956, both the quantity and quality of clinical residents began to improve.

In 1957, two small ophthalmic laboratory areas were established. One, in the basement of the medical school building (101 W. Chestnut St.), was shared with General Surgery and the eye components were financed by the Downtown Lions Club, primarily for work centered about functions of the "eye bank." The other was in the Eye Clinic area at General Hospital, financed by the Consultation fund.

In 1958, the Knights Templars and the Kappa Kappa Gamma Alumni joined in affording financial assistance and capital equipment.

In 1959, the Eye Section moved from the crowded second floor of the clinic wing to the fourth (surgical) floor where departmental lab, office and conference space was more than doubled and was no longer used conjointly with ENT.

In 1959, the Lions broadened their support to establish a "problem" Eye Clinic at General Hospital, receiving patients sponsored by their Clubs throughout Kentucky, and in 1962 to finance a research fellow, the first appointee being Ned Snider, M.D. Also, Miss Marsha Blatt, B.S., M.S., was appointed full-time Instructor in Microbiology and Virology and provided with a laboratory. She has contributed to research studies in infectious processes, to critical analysis on inflammatory cases, and to the teaching of trainees.

In 1962, the air-conditioned Reynolds Metals Company building, (3rd St. & Eastern Pkwy.) donated to the University in 1958, became available for research. Ophthalmology secured about 10,000 sq. ft. on the fourth and first floors. Under concurrent impetus of the NINDB Training Grants begun in 1957, ophthalmology was growing toward autonomous departmental status as achieved in November, 1962. A research division was inherent in the excellent Reynolds space, although disadvantageously separated from the Medical Center by 3 miles. With $16,000 of National Science Foundation matching money, the Reynolds space was remodeled and equipped with sinks, hoods and cabinetry, yielding about 6,400 net square feet for labs, offices, conference room and library, plus a 1,240 sq. ft. mechanical shop, at a cost of only $5.50 per square foot.

Roy S. Griffiths, Ph.D., transferred to the Department of Ophthalmology as a full-time research investigator in Corneal Electro-

*This is a continuation of *Development of Ophthalmology in the University of Louisville: Historical Background and Bibliography*, J.K.S.M.A. 53:871-8 (Oct.) 1955

physiology in 1963 and presented in February, 1964 the first paper to be produced from this laboratory.

Catalyzation of a true research division requires at least one full-time, senior investigator to mount a continuing and growing attack. Hugh Davson, D.Sc., from the Physiology Department, University College, London, England, was prevailed upon to bring his extensive background to this task. Financial support for such a distinguished Visiting Professor of Ophthalmic Research was provided by the University and the Department of Ophthalmology.

Doctor Davson came into ophthalmic physiology through general physiology, where his *Textbook of General Physiology* (1st Ed. 1951, 2nd Ed. 1959) has been a stimulating standard. More specifically, he studied membrane function (Davson, H. & Danielli, J. F.: *Permeability of Natural Membranes,* Cambridge, University Press, 1st Ed. 1943, 2nd Ed. 1952) and the common characteristics of cerebrospinal and aqueous fluids *(Physiology of the Ocular and Cerebrospinal Fluids,* London, J. & A. Churchill, Ltd., 1956). His first text on *The Physiology of the Eye,* Philadelphia, Blakiston Co., 1949 (451 pp.), has grown into a Second Edition, 1963 (492 pp.), and the carefully edited four volumes on basic ocular functions, *The Eye,* New York, Academic Press, 1962.

During the year prior to Doctor Davson's arrival, Robert J. Kaiser, M.D., a third-year resident, worked at the Institute of Ophthalmology, London, under Doctor Davson's associate, D. M. Maurice, Ph.D. During this time, equipment and space were largely readied for the visiting professor. Doctor Davson, arriving September 1963, brought with him Charles Purvis, instrument maker extraordinary, and L. Z. Bito, National Science Foundation Postdoctoral fellow. Doctor Davson also agreed to return during the summers of 1965, 1966 and 1967.

The need for a continuing group of basic ocular physiologists was met in 1963 with the securing of Jose Zadunaisky, M.D., from the National University of Buenos Aires, as permanent director of the Division of Ophthalmic Research. He was joined in January 1964 by two junior associates, Oscar Candia, M.D. and Jorge Fischbarg, M.D. Thus in 1964, a nucleus of postdoctoral workers in ophthalmic physiology was established. In the important field of instrument making, an excellent shop has been created and continuing workers secured.

Project grants from N.I.N.D.B., N.C.C.B., American Cancer Society, N.S.P.B., and Multiple Sclerosis Society are operative through 1966. One of Doctor Zadunaisky's NIH grants has been transferred here from Beunos Aires. Major instruments ranging up to $15,000 have been purchased by the Lions and other benefactors. An unrestricted $5,000 has been received from Research to Prevent Blindness, New York.

The Division is not only operative and growing but committed to the training of postgraduate students and technical workers.

Future Plans

The Research Division is primarily committed to ophthalmic physiology, pathology and microbiology, but other fields will be entertained if they come within staff capabilities. The Division seeks, by 1966, several senior laboratory scientists in related areas, as anatomy, electron-microscopy, biochemistry or biophysics. Proven workers at other centers will be encouraged to work here for periods as short as a few days to attack particular problem "bugs"; for intermediate collaborative periods of a few months, or for as long as a sabbatical year in which their personal studies would be furthered in these facilities.

Since 1947, an annual Visiting Professorate each February has been underwritten by the Commonwealth Fund, and since 1953 by the Guild of Prescription Opticians of Kentucky. This will be continued and expanded into the research field. These visitors will lecture, evaluate work in progress, participate in conferences and seminars.

New physical facilities for ophthalmology are in architectural planning for phased development under sponsorship of the Kentucky Lions Eye Foundation. A complete eye institute as a physical and administrative component of the School of Medicine and its teaching hospital is projected along lines similar to the Wilmer Eye Institute at Johns Hopkins. Phase one construction will be a research building of approximately 20,000 net square feet. This is being designed to accommodate use of all present equipment and cabinetry.

The ground floor of this unit will include offices, the eye bank, a conference room for approximately 35 individuals, reception rooms,

Continued on Page 140

EDITORIALS

What Now?

BILLS sponsored by Representative King and Senator Anderson proposing a cumpulsory system of hospital care for the elderly, financed under the Social Security plan, have first priority in the 89th Congress. This same proposal in varying forms has been brought before Congress regularly during the past seven or eight years, but has always failed. Proponents of HR1 and S1—the new numbers of the bills—feel that their proposals will be enacted into law and will provide government paid hospital care for about 18 million Americans 65 years of age and over who are now covered by Social Security or Railroad Retirement benefits.

Robert Hermann writing in the National Observer states: "The nation's elder citizens will find Medicare a skimpy coverage indeed for their medical needs."

What does this legislation propose to provide for nearly 20 million American citizens 65 years of age and over who are now entitled to Social Security benefit? It provides for the payment up to 60 days hospitalization in any one illness, and after this illness, if the patient requires nursing home care an additional 60 days is allowed. Beginning the second year it will provide as many as 240 home visits annually (120 visits the first year) by nurses or physical therapists if needed. It will pay for out-patient diagnostic services done during a period of 30 consecutive days in an approved hospital, which include x-rays and laboratory tests, subject to a deductible equal to one half the current average per diem rate for in-patient hospital services.

Hospital services so provided must be obtained in an approved hospital and in "skilled nursing homes". Since such institutions are largely found only in cities and medical centers —many smaller rural hospitals may not be so approved—the recipient of this proposed care will often be required to travel some distance from his home for treatment under strange surroundings and by personnel unfamiliar to him. There is no coverage for mental and tuberculosis hospitals. It does not include physician's bills except where the bill for the physicians' services is rendered through the hospital of which they are paid employees. There is no provision for the private physician or surgeon's payment.

Unlike the Kerr-Mills coverage medical care under the proposed legislation is not limited to people over 65 who are partially or totally unable to pay for their own medical services. The wage earner presently employed will not be eligible to receive the benfits of this program until he is past the age of 65 years.

Perhaps 50% of Americans past 65 years of age are able from their own resources or from financial help readily available from their families to provide their own medical care as needed. Blue Cross now carries more than five million persons of this group on their rolls and a very large percentage of these are covered with Blue Shield policies which take care of moderate medical and surgical fees for the medically indigent. Almost all states carry a program of indigent medical care and this, in the past five years, has been greatly supplmented by provisions of the Kerr-Mills law which has now been implemented in 40 states with an increasing number of participating states every year. The American Medical Association and most physicians feel that this provision renders the proposed overall coverage paid for through Social Security unnecessary and excessive.

The officers of the American Medical Association with the help of an uncounted number of physicians throughout the states, and with the cooperation of national organizations such as the Chamber of Commerce and the Farm Bureau have for the past 20 years engaged in a tireless campaign of education and shaping of public opinion. These efforts have been very effective in forestalling the enactment of these proposals. These agencies, however, have been successful in greatly modifying the original

proposals which would have brought total government control of medicine had the compulsory national health insurance of President Truman's administration been enacted.

The Trustees of the American Medical Association met in December 1964 to seriously consider what can be done this year to modify or make more equitable the medical care provisions which will almost certainly be enacted by this Congress. Robert Long, M.D., our representative on the Board of Trustees of the AMA, participated in that meeting and he and the entire Board of Trustees are hopeful that, with the consultation and advice of such authorities in this field as Representative Wilbur Mills, reasonable modification of the law may be effected which will be more generally acceptable to the medical profession and more economical in the administration of health services to older Americans according to their need. We owe a debt of profound gratitude to statesmen in the medical profession, to our friends in Congress, and to the organizations which have stood by us in our contention during these years.

Why should the practicing physician be concerned? The King-Anderson bill administered by the Federal government and paid for by Social Security will not greatly affect his income. He may even collect more money under its operation. But he will be less free in the pursuit of his practice. His judgement will be altered by government rules and by the demand of his patients for hospitalization and services not essential to their health. There will be an unnecessary demand upon hospitals already overcrowded and which now must often fail to accomodate patients critically ill. The idea of providing hospital services at government expense to millions of people well able to provide their own is repulsive.

If government controlled medical care is extended to an additional 20 million people by this law, there will then be not more than 40 million Americans covered by any form of compulsory health provisions. The practice of medicine will still be at least 75% based on free enterprise and this is perhaps a larger freedom than is exercised by the medical profession of any major country in the world.

SAM A. OVERSTREET, M.D.

Senior Day — A Program With Purpose

ANNUALLY, we look forward to this time of year, when we are finalizing plans for the now traditional KMA Senior Day Programs. Participation in this activity not only serves as a rewarding experience for the commitee members and physicians appearing on the program, but also gives up an opportunity to demonstrate our interest and welcome our future colleagues into the profession. 1965 marks the 11th consecutive year the KMA has sponsored this program for the University of Louisville senior medical students and the second year for the University of Kentucky medical students. Each program is sponsored in cooperation with the medical schools and the local county medical society.

Indeed, Senior Day is probably the first real exposure of the medical student to organized medicine and the role it serves within the profession and to the public. During his academic years, the medical student has been faced with the crowded curriculum demanded in the technical aspects of his education. On this one day, a number of KMA members from across the state get together to give their time in the hope that they can be of assistance in making the transition from a student of medicine to a practitioner of medicine an easier task.

During this day-long program, the student will hear presentations on matters such as helping him set up a practice; decide whether to practice in an urban or rural area; understand what he, as a physician, owes to his profession, his community, his family and himself; and learn the economic aspects of medicine and his responsibility in legislation and politics.

The rewards of Senior Day are shared by us all. It has proven to be of definite educational value to the students and an inspiration to the physicians. Our appreciation is extended to all those who participate in the presentation of this program. Our invitation is extended to all those who might like to attend either of these sessions.

CARL C. COOPER, JR. M.D., Chairman
KMA Senior Day Committee

ORGANIZATION SECTION



THE KMA INTERIM MEETING will be held this year on March 18 at Gabe's Restaurant in Owensboro. The restaurant offers adequate meeting facilities and will house sessions of the KMA Board of Trustees and the Board of the Woman's Auxiliary, both on March 17, as well as other meetings. Gabe's is located at 18th and Triplett Streets in Owensboro.

Five Top Guest Speakers to Discuss Important Medical Affairs At 1965 KMA Interim Meeting in Owensboro March 18

Critical problems now facing the medical profession will be examined for Kentucky physicians by five guest authorities participating in the KMA Interim Meeting in Owensboro March 18, according to Delmas M. Clardy, M.D., Hopkinsville, KMA president, who recently released the full program for the meeting.

Among the well-known speakers coming to Kentucky to take part in this important program will be Wesley W. Hall, M.D., Reno, Nev., vice-chairman of the American Medical Association Board of Trustees, and Austin Smith, M.D., President of the Pharmaceutical Manufacturers' Association and former editor of The Journal of the AMA.

Voter Registration Deadline is March 26

Your vote is important in the May primary elections. All of the state representatives, approximately half the state senators, and a number of local officials will be voted on in the primary May 25. So that you may cast your ballot in this election, you must be registered before Friday, March 26. Registration books will be closed on that date. If you have moved within the past year, you are urged to check your voting status with your county court clerk.

Doctor Hall, who is known to many Kentucky physicians through his activities in organized medicine, will address the afternoon session on "Doctors and Government". Doctor Smith will discuss "Changing Concepts in the Health Field" at the Luncheon Session. Both talks, Doctor Clardy said, should provide stimulating insight into these areas of immediate interest.

"Blue Shield—1965 Variety", will be the topic of Russell B. Carson, M.D., Fort Lauderdale, Fla., who will speak at the morning session. Doctor Carson will summarize the present composition of Blue Shield as a national organization, the trends which it has taken in recent years, and other aspects of the Blue Shield Plans.

Doctor Smith previously held positions with the AMA as secretary of its Council on Pharmacy and Chemistry (now the Council on Drugs), and as director of the Division of Therapy and Research. He is a member of the Advisory Council of the Student AMA, and the Advisory Committee of the AMA Council on Rural Health. Doctor Smith received his medical degree from Queen's University of Canada.

Doctor Hall, a 1930 graduate of Tulane University School of Medicine, is a native of Mississippi. In 1952 Doctor Hall, a general surgeon, was elected Nevada's delegate to the AMA House of Delegates,

Continued on Page 120



Doctor Smith

Program

KMA 1965 Interim Meeting

Gabe's Restaurant, Owensboro

Thursday, March 18



Doctor Hall

MORNING SESSION

Delmas M. Clardy, M.D., Hopkinsville, President
Kentucky Medical Association, Presiding

8:45 a.m.* **Registration**

9:00 a.m. **Coffee Call**

9:30 a.m. **Call to Order,** Doctor Clardy
Invocation, Reverend Jack E. Keeney, Trinity Methodist Church, Owensboro
Welcome, William W. Hall, M.D., Owensboro, President, Daviess County Medical Society
Announcements, Henry B. Asman, M.D., Louisville, KMA Secretary

9:45 a.m. **"Blue Shield—1965 Variety",** Russell B. Carson, M.D., Fort Lauderdale, Florida, Chairman of the Board of the National Association of Blue Shield Plans

10:15 a.m. **"A Consumer and Hospital Trustee looks at Area Wide Hospital Planning",** Mr. Nathan J. Stark, Kansas City, Missouri, Vice-President of Hallmark Cards, Inc.

10:45 a.m. **Coffee Break**

11:00 a.m. **"Interprofessional Relations—A Two-Way Street",** Mr. Robert E. Lee, Tucson, Arizona, member of the Council of the American Pharmaceutical Association

11:30 a.m. **Question and Answer Session**—The audience is requested to submit written questions

LUNCHEON SESSION

Doctor Clardy presiding

12:30 p.m. **"Changing Concepts in the Health Field",** Austin Smith, M.D., Washington, D. C., President of the Pharmaceutical Manufacturers' Association

AFTERNOON SESSION

Everett H. Baker, M.D., Louisville,
KMA President-Elect, Presiding

1:45 p.m. **"Doctors and Government",** Wesley W. Hall, M.D., Reno, Nevada, Vice-Chairman of the Board of Trustees of the American Medical Association

2:30 p.m. **"Legislation—State Affairs,"** James C. Cantrill, M.D., Georgetown, Kentucky, Chairman for State Affairs, KMA Council on Legislative Activities.

2:45 p.m. **"Legislation—National Affairs."** John C. Quertermous, M.D., Murray, Kentucky, Chairman for National Affairs, KMA Council on Legislative Activities.

3:00 p.m. **Adjournment**

**All times listed Central Standard Time*



Mr. Lee



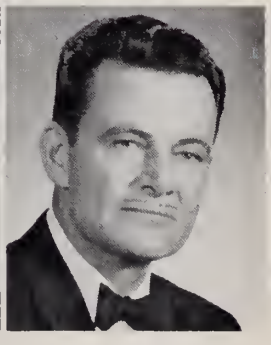
Mr. Stark



Doctor Cantrill



Doctor Carson



Doctor Quertermous

where he served until his election to the Board of Trustees. He was chosen vice-chairman of the Board in 1964.

Chairman of the Board of the National Association of Blue Shield Plans, Doctor Carson has served Blue Shield in many capacities on state and local levels. In 1954 he became a member of the Board of the Florida Blue Shield Plans, and was elected president in 1955, serving in that office for eight years. He was elected secretary of the National Association of Blue Shield Plans in 1962, and became chairman of the Board in 1964.

Legislative Matters to be Topic

Following Doctor Hall's presentation at the afternoon session, there will be two discussions on state and national legislative affairs. James C. Cantrill, M.D., Georgetown, chairman for State Affairs of the KMA Council on Legislative Activities, will discuss state and local legislative matters. John C. Quertermous, M.D., Murray, chairman for National Affairs for the Council, will close the program with a talk on national legislation.

Doctor Quertermous, a 1942 graduate of the University of Louisville School of Medicine, is a delegate from the KMA to the American Medical Association. He has served as a member of the KMA Committee on Aging, the Advisory Committee to the University of Louisville School of Medicine, and the Committee on Postgraduate Medicine.

Doctor Cantrill, who graduated in 1950 from the University of Virginia School of Medicine, has been in general practice in Georgetown since 1954. He has served the KMA as Sixth District Key Man, and has been secretary-treasurer and president of the Scott County Medical Society. He is a veteran of World War II and the Korean War.

Pharmacist; Hospital Expert to Speak

Other speakers on the program will be Mr. Nathan Stark, Kansas City, Mo., and Mr. Robert E. Lee, Tucson, Ariz., information on whom appeared in last month's Journal. Mr. Stark, president of Hallmark Cards, Inc., will discuss area wide hospital planning from the viewpoint of a consumer and hospital trustee. Mr. Lee, a member of the Council of the American Pharmaceutical Association, will speak on "Interprofessional Relations—A Two-Way Street".

Gabe's Restaurant, Owensboro, well known for its meeting facilities and its fine cuisine, will be the location of this year's meeting. Motels and hotels in the area, including Gabe's Motor Inn, next door to the restaurant, will provide accommodations.

A day-long meeting of the KMA Board of Trustees will be held March 17 at Gabe's. The Board of Trustees of the Woman's Auxiliary will also meet at that time.

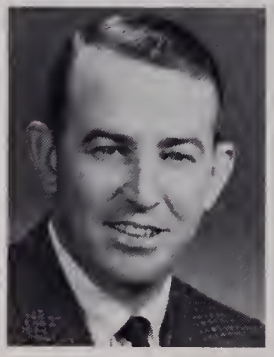
Nominating Committee to Meet Mar. 18 at Interim Meeting

The KMA Nominating Committee to present nominations for general officers at the 1965 KMA Annual Session will hold its first meeting at an especially marked table during the luncheon session of the Interim Meeting in Owensboro March 18.

The KMA Awards Committee will meet in like manner during the luncheon at Gabe's Restaurant. All KMA members are invited to submit suggestions to these committees.

Dr. Barton Elected Chairman of KEMPAC Board

Harold B. Barton, M.D., Corbin, KMA vice-president from Eastern Kentucky, was elected chairman of the Board of Directors of the Kentucky Educational Medical Political Action Committee at a Board meeting January 13 at Louisville.



Doctor Barton

He succeeds Hoyt D. Gardner, M.D., Louisville, who has accepted a position on the Board of directors of the American Medical Political Action Committee (AMPAC). A story on Doctor Gardner's election is on page 121 of this issue.

Doctor Barton, a 1952 graduate of the University of Louisville School of Medicine, maintains a private practice in surgery in Corbin. A graduate of Williamsburg High School, he attended the University of Kentucky. Doctor Barton is a member of the American College of Surgeons. He is a veteran of World War II.

In other action taken during the January 13 meeting, the KEMPAC Board elected Richard F. Greathouse, M.D., Louisville, as secretary-treasurer of the Board. Doctor Greathouse will also serve as district chairman, a new position created for the purpose of maintaining close liaison with the KEMPAC headquarters in Louisville.

SMA Specialty Sections Elect

Three Kentucky physicians have been named to offices in their respective specialty group sections of the Southern Medical Association, it was recently announced.

W. Vinson Pierce, M.D., Covington, was elected vice-chairman of the Section of Urology; Andrew M. Moore, M.D., Lexington, is chairman-elect of the Section on Plastic and Reconstructive Surgery, and Douglas M. Haynes, M.D., Louisville, is secretary of the Section on Obstetrics. These officers will assist in arranging programs for their sections at the 59th annual meeting of the SMA in Houston, Tex., November 1-4.

Annual Senior Days Scheduled For U.L., U.K. Students

For the second consecutive year, two KMA Senior Day Programs will be presented by the state association, according to Carl Cooper, M.D., Bedford, chairman of the KMA Senior Day Program.

The first session for 1965 will be the Eleventh annual Senior Day Program for the University of Louisville senior medical students, which will be held March 15 in Louisville. Again this year the program will be sponsored by KMA in cooperation with the University of Louisville School of Medicine and Jefferson County Medical Society.

The second annual Senior Day for the University of Kentucky seniors will be presented in Lexington April 13 with the cooperation of the University of Kentucky College of Medicine and the Fayette County Medical Society.

Delmas M. Clardy, M.D., Hopkinsville, KMA president, will open both sessions with an address entitled "the Great Society of Mediocrity". Each of the programs will incorporate such topics as "The Human Equation Medical Practice", "Legislation and Politics", "Where You Practice", and "Economics of Medicine".

A nationally known speaker will be featured in each of the evening sessions following a social hour and dinner at which the individual members of the county medical society are hosts to the individual members of the senior medical classes.

McDowell House Recognized

McDowell House at Danville, the restored home of pioneer physician Ephraim McDowell, has been designated a national historic landmark by the U.S. Department of Interior, Kentucky Senator John Sherman Cooper, Somerset, announced in mid-January.

McDowell House, owned and maintained as a shrine by KMA, was named as a leading site among 27 commemorating America's scientific and technological advances. The site will receive a certificate and a bronze placque.

Ky. Ob-Gyn Society to Meet Apr. 1

The Kentucky Obstetrical and Gynecological Society will hold its 1965 Annual Meeting April 1 and 2 in conjunction with the symposium on Genito-Urniary Diseases sponsored by the University of Kentucky department of Radiology March 29-April 2, at the U.K. Medical Center.

C. Paul Hodgkinson, M.D., Detroit, and Kaighn Smith, M.D., Philadelphia, will be the featured speakers at the Obstetrical and Gynecological sessions, according to Philip Crossen, M.D., Lexington, secretary of the society. Other papers will be delivered by faculty members of the departments of obstetrics and gynecology and radiology. Further details of the meeting will be published later.

Medical-Dental Complex Planned for U. of L.

The University of Louisville on January 21 announced plans for the construction of a new $24 million complex for the use of the Medical and Dental Schools. Funds for the project are expected to come from Federal, state and local bond issues.

Due to the nearness of The Journal's deadline when this announcemnt was made, it was impossible to carry a full story on the projected construction. Full details will be published in the March issue of The Journal.

AMA Trustees Elect Dr. Gardner To Serve on AMPAC Board

Hoyt D. Gardner, M.D., Louisville, has been elected to serve as a member of the Board of Directors of the American Medical Political Action Committee effective January 1, 1965 by the Board of Trustees of the American Medical Association.



Doctor Gardner

Doctor Gardner is the retiring chairman of the Kentucky Educational Medical Political Action Committee Board of Directors and served as secretary of the Board from the time it was organized until he became chairman. He has been active in county and state medical organizational work since he entered practice.

Like KEMPAC, AMPAC is not affiliated with either major political party. It bases its support on the platform and program of the individual candidate.

Other physician members of the AMPAC Board are M. Vaun Adams, Mobile, Alabama; Frank C. Coleman, Tampa, Florida; Blair J. Henningsgaard, Astoria, Oregon; John R. Kernodle, Burlington, North Carolina; George J. Lawrence, Flushing, New York; James H. Sammons, Highlands, Texas; Malcolm C. Todd, Long Beach, California; Donald E. Wood, Indianapolis, Indiana; and Mrs. Frank Gastineau, also of Indianapolis.

Genito-Urinary Symposium Set

A symposium on Genito-Urinary Disease, conducted by the University of Kentucky Medical Center Department of Radiology, will be held at U.K. March 29 to April 2.

In addition to individual papers, the program will feature panel discussions on such subjects as Bladder Outlet Obstruction in Childhood, and Renovascular Hypertension. For further information, please contact Nicholas J. Pisacano, M.D. Director, Continuing Education, U.K. Medical Center, Lexington, Ky. 40506.

Dr. Clark to Head New Dept. Of Neurology at U. of K.

David B. Clark, M.D., associate professor of medicine and pediatrics at Johns Hopkins, has been named chairman of the University of Kentucky Medical Center's new department of neurology, created by the University Board of Trustees at its January meeting.

Doctor Clark, who will assume his new post June 1, is also the attending neurologist and pediatrician at the Johns Hopkins Hospital. He holds both M.D. and Ph.D. degrees from the University of Chicago.

During the war years, Doctor Clark worked with the Office of Scientific Research Development on chemical processes. He went to Johns Hopkins in 1948, where he has progressed from instructor to associate professor in medicine, pediatrics and pathology.

Doctor Clark was a Fulbright lecturer in neurology at the National Hospital for Nervous and Mental Diseases in London in 1950. He is a member of the American Board of Psychiatry and Neurology, the Royal Society of Medicine, the Southern Medical Association, the American Academy of Neurology, the American Neuropathological Association, and the American Neurological Association.

KMA Announces New Members; Associate Members

Thirteen physicians have become new members of the Kentucky Medical Association, according to a report dated January 10 from the KMA membership office. The names of six new associate members have also been announced. The membership office lists the following new members:

P. R. Caffrey, M.D., Carl T. Evans, M.D., Dale H. Farabee, M.D., Michael L. Furcolow, M.D., R. F. Hench, M.D., Horace A. Norell, Jr., M.D., Irene Roeckel, M.D., and Charles W. Taylor, M.D., all of Lexington.

New members from Louisville are: Robert E. Amis, M.D., Samuel L. Cooke, M.D., Ernest C. Holbrook, M.D., Norman H. Liebschutz, M.D., Roger D. Salot, M.D., Richard L. Strom, M.D., and Chalmer S. Wheeler, M.D. Others are Frank A. Shemwell, M.D., Paducah, and Orville J. Stein, M.D., Somerset.

Dr. Fadell Heads Pathologists

E. J. Fadell, M.D., Louisville, was installed January 16 as president of the Kentucky Society of Pathologists during a meeting of the Society at the Essex House in Louisville. Wellington B. Stewart, M.D., Lexington, was named president-elect of the group.

Doctor Stewart is professor and chairman of the department of pathology at the University of Kentucky Medical Center. Doctor Fadell is an assistant clinical professor of pathology at the University of Louisville. John D. Allen, M.D., Louisville, is continuing his term as secretary of the Society.

Ky. Surgeons to Meet Apr. 9-10

The Kentucky Chapter of the American College of Surgeons will have the opportunity April 9-10 to hear five highly ranked guest speakers who will present papers at the annual meeting of the chapter at Paducah's Holiday Inn, R. W. Robertson, M.D., Paducah, chapter president, announced recently.

Doctor Robertson listed the following participants: Ben Colcock, M.D., Langdon Parson, M.D., Claude Welch, M.D., all of Boston; and Marcus Stewart, M.D., Memphis. James Spencer ,M.D., of the American College of Surgeons Staff, will be the dinner speaker April 9. Biographical information on the speakers and full program details will appear in a later issue of The Journal.

SE Surgical Congress to Meet

Four Kentuckians will take part in the program of the Southeastern Surgical Congress at the Statler Hilton Hotel in Washington, D.C. on March 29-April 1, J. Duffy Hancock, M.D., Louisville, councilor for Kentucky, announced.

Doctor Hancock will serve as moderator for the morning program on March 31. Francis M. Massie, M.D., Lexington, councilor-at-large of the Congress, wil speak on "Controlling Surgical Infections". Also appearing on the program will be Laman A. Gray, M.D., Louisville, whose topic will be "Carcinoma of the Ovary and Endometriosis" and Marion Carnes, M.D., Lexington, who will discuss "Handling Postoperative Complications of Anesthetized Patients."

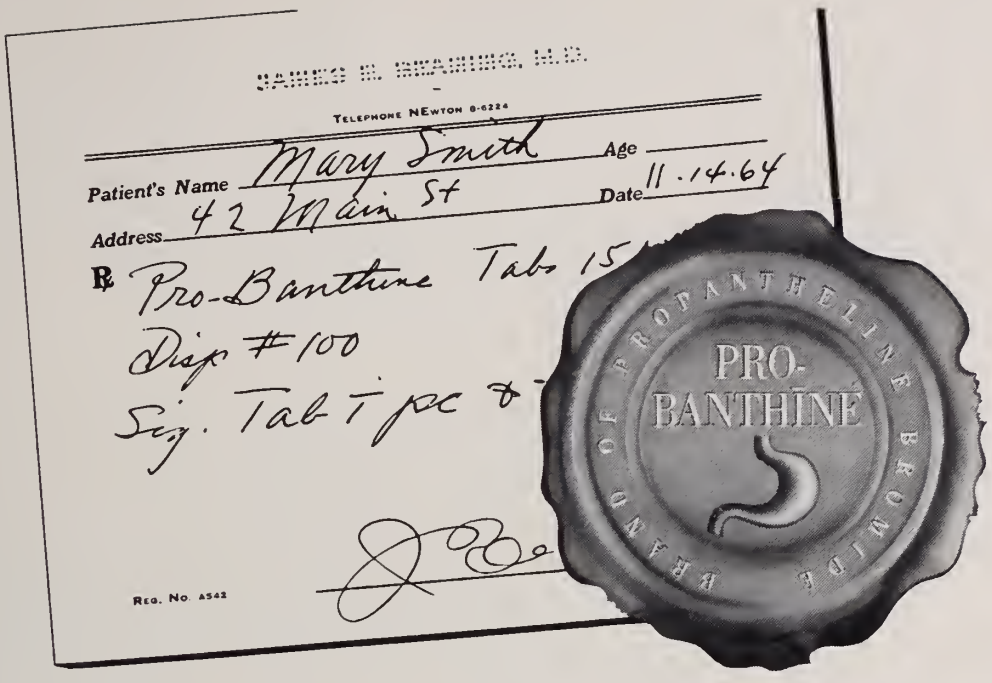
Lexington Clinic Program Set

The Tenth Annual Clinical Lexington Clinic Conference, sponsored by the Kentucky Academy of General Practice and the Clinic, will be held at the Clinic April 1, according to Leslie W. Blakey, M.D., and C. Richard Gill, M.D., Lexington, who are in charge of the program.

Earl K. Shirey, M.D., Cleveland, O., of the Cleveland Clinic, and Warren Wheeler, M.D., professor and chairman of the department of pediatrics at the University of Kentucky College of Medicine, will be the featured guest speakers on the program. Individual papers and panel discussions will be presented by members of the Lexington Clinic staff. The full program of the Conference will be carried in the March issue of The Journal.

KAGP Will Meet May 5-7

May 5-7 are the dates of the Kentucky Academy of General Practice annual meeting to be held at the Kentucky Hotel in Louisville, according to E. C. Seeley, M.D., London, KAGP president. William VonderHaar, M.D., Louisville, is chairman of the KAGP council on Scientific Assembly, in charge of the program. The full details of the meeting will appear in a later issue of The Journal.



Stamp of Approval on Virtually any Ulcer Regimen–

PRO-BANTHĪNE®

(propantheline bromide)

Historically, reduction of acid and motility in peptic ulcer has been approached through the use of antacids, dietary management and surgery.

Since 1953, however, Pro-Banthīne used alone or in addition to other measures has contributed importantly to achieving both of these goals. It has been shown repeatedly that adequate doses of Pro-Banthīne will significantly inhibit gastric acid secretion and reduce gastrointestinal motility.

So dependable have these actions been that now, for many, standard treatment of peptic ulcer and several allied conditions has become antacids *plus* Pro-Banthīne, dietary management *plus* Pro-Banthīne, surgery *plus* Pro-Banthīne, or some combination of the three.

Pro-Banthīne has become the most widely prescribed anticholinergic for patients with peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia because patients respond favorably to its therapeutic actions.

Side Effects and Precautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Dosage—The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six tablets daily in divided doses. In severe conditions as many as four tablets may be given four times daily. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

SEARLE

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Research in the Service of Medicine

Ky. Physicians Elected Fellows, Associate Members of ACP

Twelve Kentucky Physicians were among those recently elected by the American College of Physicians to associate membership and fellowship, according to Carl H. Fortune, M.D., Lexington, Governor for Kentucky of the ACP.

Elected to fellowship were the following: Jerome E. Cohn, M.D., and John E. Meyers, M.D., both of Lexington; and William A. Blodgett, M.D., Grover B. Sanders, M.D., and Edwin P. Scott, M.D., all of Louisville.

The ACP listed as new associate members John E. Cotthoff, M.D., Hopkinsville; Charles R. Gill, M.D., David H. Johnston, M.D., and Kenneth C. Tufts, M.D., all of Lexington; and Sanford P. Greiver, M.D., A. Evan Overstreet, M.D., and William B. Stodghill, M.D., all of Louisville.

Ky. Thoracic Society to Meet

The Kentucky Thoracic Society will meet at the U.K. Medical Center April 22-23 in conjunction with the annual meeting of the Kentucky Tuberculosis and Respiratory Disease Association, according to Lloyd D. Mayer, M.D., Lexington, KTS program chairman.

An impressive list of out-of-state guest speakers have accepted invitations to address the meeting, Doctor Mayer said. Among them he listed: K. Frank Austin, M.D., Boston; Tom Dy Chinn, M.D., Kansas City; George W. Comstock, M.D., Baltimore; James E. Perkins, M.D., New York; and Noel Rose, M.D., Buffalo. Michael L. Furcolow, M.D., Lexington, will also present a paper at the meeting.

Dr. Moller Installed Jan. 17

Charles F. Moller, M.D., Lexington, was installed as president and George W. Schafer, M.D., Louisville, was chosen president-elect of the Kentucky Society of Anesthesiologists at its January 17 meeting at the Holiday Inn on Brownsboro Road in Louisville.

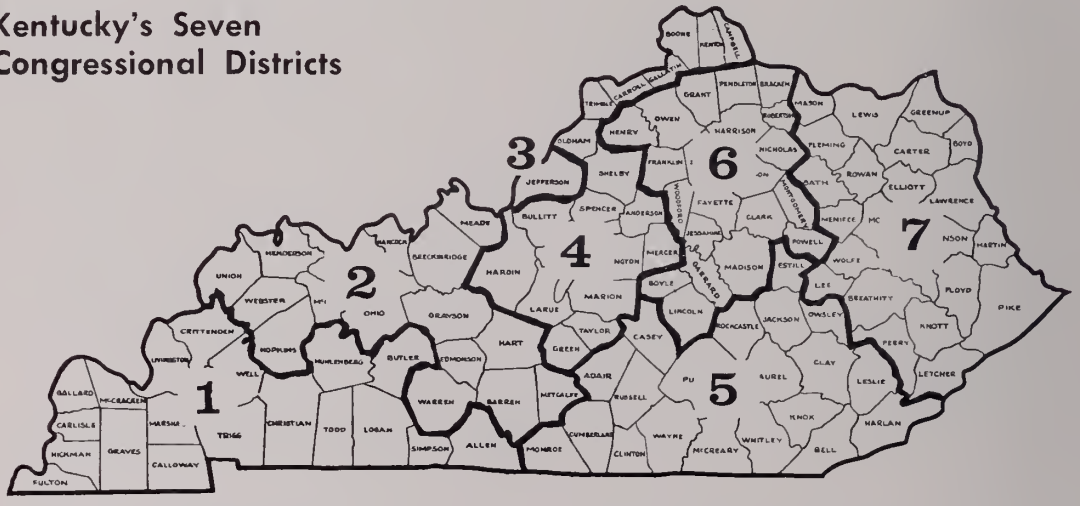
William E. Hopkins, M.D., Louisville, was elected vice-president. Orville Clark, M.D., Louisville, secretary, is serving the second year of a two year term. "Microcirculation in Shock" was the topic of Louis Orkin, M.D., professor and chairman of the department of Anesthesiology at Albert Einstein Medical College, New York City, who was the guest speaker on the scientific program.

A CORRECTION

In the January issue of The Journal on page 50, an article in which a congressional map was included gave the name of Kentucky's Senators and Representatives.

Inadvertantly an old map showing eight congressional districts was included in the article. We apologize for this oversight and show the current map with the present seven congressional districts and a list of U.S. Senators and Representatives from each district.

Kentucky's Seven Congressional Districts



CONGRESSMEN*

District

1 Frank A. Stubblefield (D), Murray
2 William H. Natcher (D), Bowling Green
3 Charles Farnsley (D), Louisville
4 Frank L. Chelf (D), Lebanon
5 Tim Lee Carter, M.D., (R), Tompkinsville
6 John C. Watts (D), Nicholasville
7 Carl D. Perkins (D), Hindman

Address Congressmen at House Office Building, Washington, D. C.

SENATORS*

John Sherman Cooper (R), Somerset
Thruston B. Morton (R), Louisville

Address Senators at Senate Office Building, Washington, D. C.



eping better, Mrs. Smith?



My, yes! I'm not tired out anymore.



Headaches still bother you?



at all. I feel wonderful!



Mmm. Normal. Must be taking your Regroton.



One a day at breakfast. Sure is easy on me.



e. I'm cutting you down to a tablet daily.



Thanks for everything, Doctor. See you on the 3rd.



...excellent response to Regroton, from 196/120 to 145/90.

position: Each tablet contains chlorthalidone, g., and reserpine, 0.25 mg.
raindications: History of mental depression, rsensitivity, and most cases of severe renal epatic diseases.
ning: Discontinue 2 weeks before general thesia, 1 week before electroshock therapy, if depression or peptic ulcer occurs.
autions: Reduce dosage of concomitant anti-rtensive agents by one-half. Discontinue if BUN rises or liver dysfunction is aggravated. trolyte imbalance and potassium depletion occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

Availability: Bottles of 100 and 1000 tablets.
Average Dosage: One tablet daily with breakfast.

*Chupkovich, V., Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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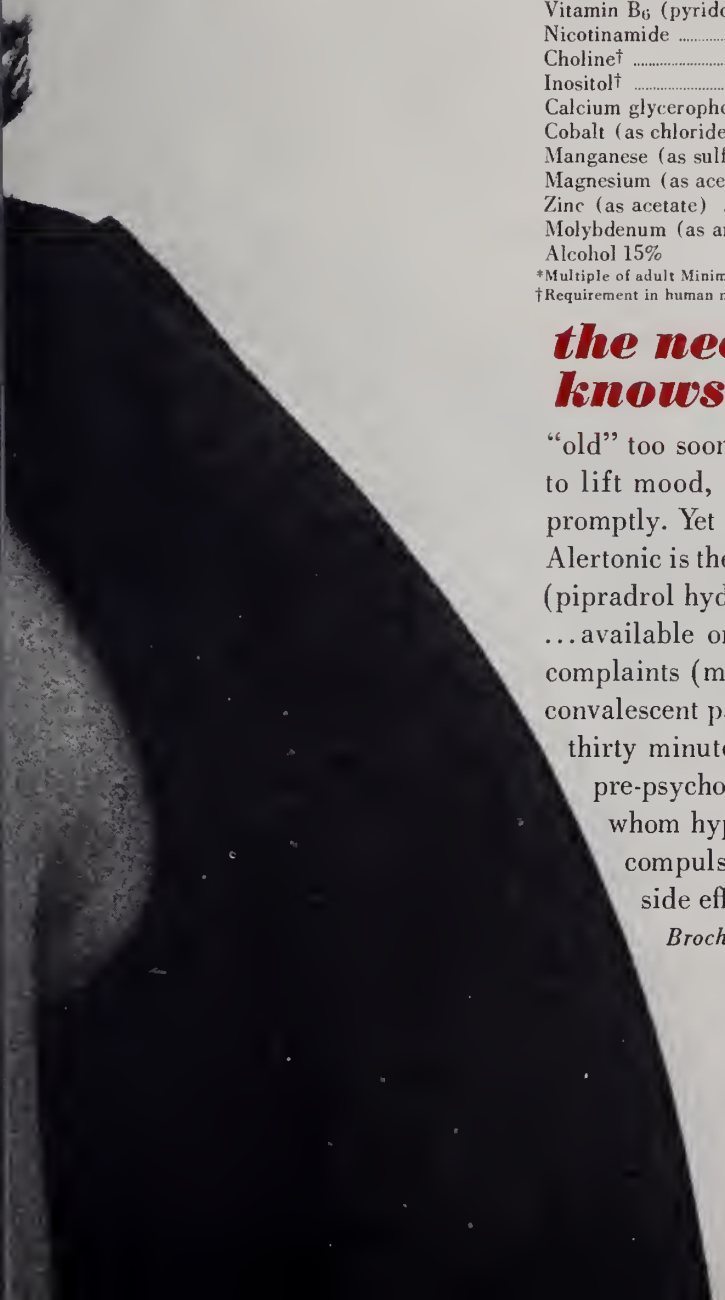
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Superior to other antihypertensives in 76 of 80 patients during a 2-year study*

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revive interest... restore activity promptly with

Alertonic®

Three tablespoonfuls (45 cc.) contain:		
Pipradrol hydrochloride		2 mg.
Vitamin B_1 (thiamine hydrochloride)	(10 MDR*)	10 mg.
Vitamin B_2 (riboflavin)	(4 MDR*)	5 mg.
Vitamin B_6 (pyridoxine hydrochloride)		1 mg.
Nicotinamide	(5 MDR*)	50 mg.
Choline†		100 mg.
Inositol†		100 mg.
Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
Cobalt (as chloride)		1 mg.
Manganese (as sulfate)		1 mg.
Magnesium (as acetate)		1 mg.
Zinc (as acetate)		1 mg.
Molybdenum (as ammonium molybdate)		1 mg.
Alcohol 15%		

*Multiple of adult Minimum Daily Requirement supplied
†Requirement in human nutrition not yet established

the need for a tonic knows no age

Anyone can feel tired and "old" too soon. In such functional fatigue, Alertonic helps to lift mood, revive interest, restore purposeful activity promptly. Yet it contains no MAO inhibitors, no hormones. Alertonic is the effective formulation of a cerebral stimulant (pipradrol hydrochloride), alcohol, vitamins, and minerals ...available on prescription *only*. For common functional complaints (mild mood depression, tiredness); geriatric or convalescent patients, Rx one *tablespoonful* Alertonic *t.i.d.*, thirty minutes before meals. Contraindicated in agitated pre-psychotic patients, paranoia, or other patients in whom hyperexcitability, anxiety, chorea, or obsessive-compulsive states are present. Mild central stimulant side effects may occasionally occur.

Brochure with full product information available on request.

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Digest of the Proceedings of the KMA Board of Trustees Meeting

December 10, 1964

The meeting opened with the report of the president, Delmas M. Clardy, M.D., who gave a summary of his busy schedule, which included a number of speaking engagements.

Following the headquarters office report, submitted by the secretary, Henry B. Asman, M.D., the delegates and alternate delegates to the AMA gave a summary of the activities in the House of Delegates at the 1964 AMA Interim Meeting in Miami.

Recommendations of the Executive Committee for three physicians to be nominated for each of the two vacancies on the State Board of Health were approved.

The name of the Federal Medical Services Committee was changed to Governmental Medical Services Committee and the Executive Committee was instructed to add names of physicians from Eastern Kentucky to the committee.

The Board authorized the Executive Committee to redraft the Oath of Office. Recommendations of the Technical Advisory Committee to the Governor's Council on Indigent Care were heard and discussed at length. The Board approved the recommendations.

A replacement for an appointee on the Council on Legislative Activities who could not serve, was made. Other recommendations from the Council on Legislative Activities included a revision of the Key Man System, consideration of possible revision of the medical examiner system and the operation of the Hill-Burton program.

The proposal that KMA participate with certain voluntary health groups in health education advertising was approved in principle by the Board and it delegated to the Executive Committee the responsibility of implementing the plan.

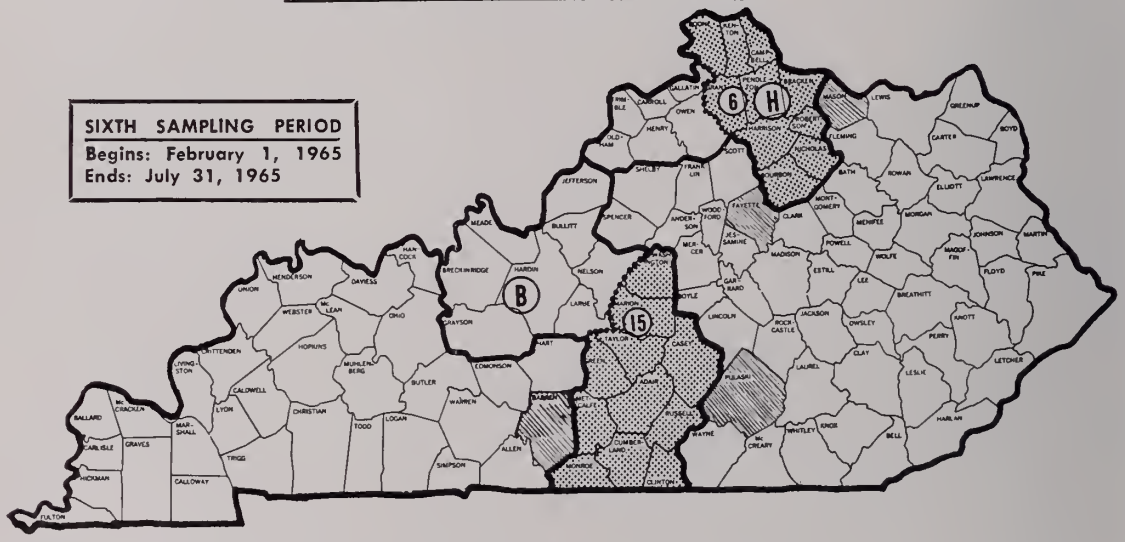
Two matters that had been under consideration by the Association in the field of ethics were referred to the KMA Judicial Council. A request for an appropriation for expenses for the two Senior Day programs was approved. Appreciation was expressed to the District V of Obstetrics and Gynecology for a gift of $1,000 to the McDowell House.

The Board unanimously approved a motion expressing appreciation to the Kentucky Public Health Physicians Association for pledging its full effort towards making the Kerr-Mills program more effective.

Recommendations for membership on the Board of Directors of the Kentucky Education Medical Political Action Committee for 1965 were made and approved. The Board is composed of one member from each congressional district, three members at large and one member from the Woman's Auxiliary.

The Board adjourned after agreeing to meet in Owensboro March 17 in a day long session at Gabe's Restaurant.

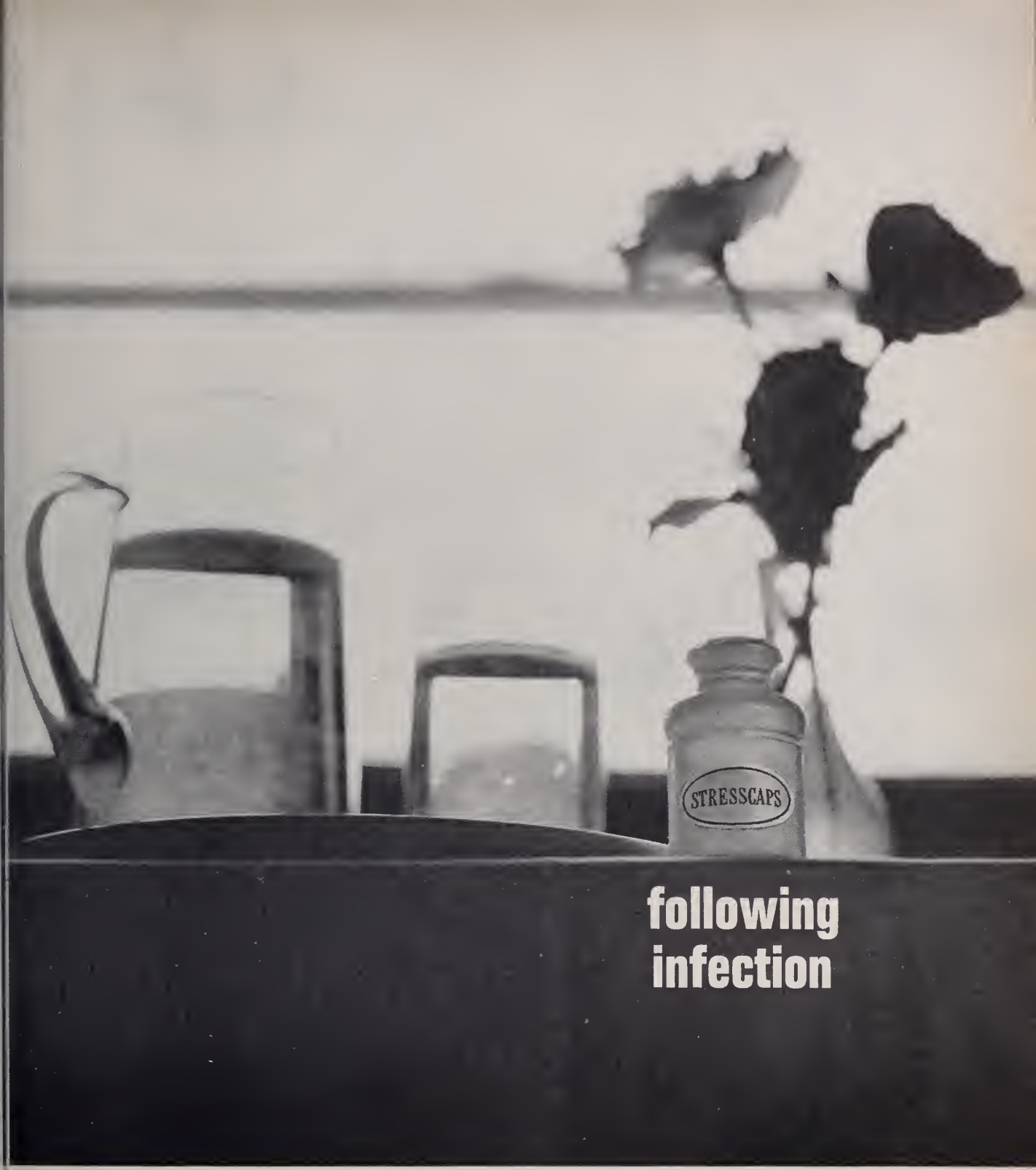
KENTUCKY—CORNELL AUTOMOTIVE CRASH INJURY RESEARCH



Area subject to ACIR study of injury producing passenger car accidents

Fringe Counties in which hospitals are used

The dark areas on the map above are those from which automobile injury samples will be taken during the six-month sampling period from February 1, 1965 through July 31, 1965. This sampling period marks the final phase of the Kentucky-Cornell Automotive Crash Injury Research program, a project being carried on by the Cornell University Aeronautical Laboratory in cooperation with the Kentucky Medical Association, the State Department of Health, the Kentucky Hospital Association, and the State Police. Data collected by this means from cooperating states have served to guide automobile manufacturers in making important design changes, incorporating safety features.



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STRESSCAPS B and C vitamins in therapeutic amounts... help the body mobilize defenses during convalescence...aid response to primary therapy. The patient with a severe infection, and many others undergoing physiologic stress, may benefit from STRESSCAPS.

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Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 (one month's supply) and 100 (three months' supply).

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News Items

James R. Collins, M.D., has joined the staff of the anesthesiology department of the University of Kentucky Medical Center. Doctor Collins, a graduate of the University of Buffalo, N.Y. His residency was completed in Western Reserve University Hospitals of Cleveland.

Eric Pfeiffer, M.D., a psychiatrist, has joined the staff of the U. S. Public Health Service Hospital at Lexington, it was recently announced. A native of Germany, Doctor Pffeiffer is a 1960 graduate of the Washington University School of Medicine and interned at Bronx Municipal Hospital, Bronx, N.Y.

James E. Anderson, M.D., will be associated with **Howell J. Davis, M.D., Royce E. Dawson, M.D.**, and **William A. McManus, M.D.**, at Owensboro, where his practice will be limited to general surgery and oncology. A 1956 graduate of the University of Tennessee School of Medicine, Doctor Anderson interned at Harper Hospital, Detroit and served his residency at Emory University Hospital and the Atlanta V.A. Hospital.

Eugene H. Kremer, III, M.D., has become associated with **Eugene H. Kremer, Jr., M.D.** at Louisville, where he will practice general medicine. Doctor Kremer, III, is a 1963 graduate of the University of Louisville School of Medicine and interned at St. Elizabeth Hospital in Dayton, Ohio.

A. C. Kennedy, M.D., has joined **W. B. Blue, M.D.**, in general practice at Doctor Blue's office at Henderson. Doctor Kennedy has been in practice in Louisville for the past nine years. He graduated in 1954 from the University of Louisville School of Medicine and interned at Good Samaritan Hospital in Lexington.

Francis M. Wilson, M.D., a 1953 graduate of the University of Arkansas School of Medicine, will practice general surgery at Madisonville in association with the Trover Clinic, it was recently announced. Doctor Wilson interned at Hillcrest Hospital in Tulsa, Oklahoma, and was a surgical resident at the Harlan Memorial Hospital at Harlan, Kentucky and at the V.A. Hospital in Bay Pine, Florida. He formerly practiced at Elizabethton, Tennessee.

Jaycees to Collect Sample Drugs

The Kentucky Junior Chamber of Commerce is again participating in Project Concern, a program to collect sample drugs from physicians to be sent for use by Jim Turpin, M.D., a medical missionary in Hong Kong. The drugs will also be used in a mission recently established in Vietnam by Doctor Turpin.

Kentucky physicians are asked to cooperate in this program by contacting Jaycees in their areas and requesting collection of the drugs. Drugs will be stored locally until the week of March 8-13, when they will be transported to Louisville for central collection and shipment.

Emergency Medical Identification Now Being Widely Used in Ky.

The universal Emergency Medical Identification symbol, approved by the American Medical Association House of Delegates in June, 1963, has received considerable recognition in Kentucky since the emblem first appeared in this Journal in January, 1964.



The emblem is designed in the shape of a traffic *Stop* sign, a shape familiar to most Americans.

Within the outline is the star of life, similar to the asterisk, which refers one elsewhere for more information . . . In this case to a purse, wallet, or inside pocket where the wearer would carry information pertinent to his own medical problem. Superimposed on the star is the staff of Aesculapius, the insignia of the medical profession.

The symbol may be used by many individuals to indicate allergies to drugs; diabetes, epilepsy, or many other physical problems. Information on obtaining identification may be gotten from the KMA Headquarters Office.



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in premenstrual tension

Complete information and clinical samples will be sent upon request.

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"Gesundheit!"

...is just for the sneeze

but for symptomatic relief of the common cold...

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Each layered tablet contains:

'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Phenacetin	150 mg.
Aspirin	200 mg.
Caffeine	30 mg.

To relieve the aches, pains, fever and respiratory congestion of the common cold, flu or grippe with one product ...specify 'Emprazil'.

Caution: While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed.

Supplied: Bottles of 100 and 1000.

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Complete literature available on request from Professional Services Dept. PML.

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Radiologists Elect Dr. Rosenbaum

Harold Rosenbaum, M.D., Lexington, was installed as 1964-65 president of the Kentucky Radiology Society, now the Kentucky Chapter of the American College of Radiology, at a recent meeting, it was announced.

Thomas R. Marshall, M.D., Louisvile, is president-elect, and Robert H. Greenlaw, M.D., was chosen as secretary. The meeting was held at the Sheraton Hotel in Louisville.

Gross Lecture Set Apr. 21

The 24th Annual Samuel D. Gross Lecture, sponsored by Phi Delta Epsilon Fraternity and the University of Louisville, has been scheduled for April 21 at Rankin Amphitheatre, Louisville General Hospital.

Alvan R. Feinstein, M.D., associate professor of medicine at Yale University School of Medicine, will be the featured guest speaker.

Ky. M.D.s on Dental Program

Marion F. Beard, M.D., Ralph M. Denham, M.D., and George W. Pedigo, M.D., all of Louisville, will be guest panelists at the April 5 session of the Kentucky Dental Association Annual Meeting in Louisville, according to R. Burke Coomer, D.D.S., Louisville, KDA president.

"Management of Dental Problems in Patients with Cardiovascular Disease" will be the topic of the discussion, Doctor Coomer said. The Dental Association will meet April 4-7 at the Brown Hotel.

Correction

It was erroniously reported in the November, 1964 issue of The Journal that George M. Gumbert, Jr., M.D., Lexington, had been elected president of the Flying Physicians' Association. Doctor Gumbert was elected secretary of the FPA. The Journal apologises for this mistake.

Three Ky. M.D.s Publish Books

Three Kentucky physicians, all members of the faculty of the University of Louisville School of Medicine, have recently published medical books.

Laman A. Gray, M.D., clinical professor of obstetrics and gynecology, is the editor of and contributor to "Dysplasia, Carcinoma in Situ and Micro-Invasive Carcinoma of the Cervix Uteri". The book was published by the Charles C. Thomas Company, Springfield, Ill. "Pediatric Procedures" is the title of the book by Walter T. Hughes, M.D., assistant professor of pediatrics at U. of L. Doctor Hughes' book was published recently by the W. B. Saunders Company, Philadelphia. Benjamin B. Jackson, M.D., research associate in surgery, is the author of "The Superior Mesenteric Artery", also published by Charles C. Thomas. A review of Doctor Gray's book appears in the book review section of this issue of The Journal.

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the long-acting diuretic

Indications
Many types of edema involving retention of salt and water.

Contraindications
Hypersensitivity, and most cases of severe renal or hepatic disease.

Precautions
Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Side Effects
Constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, leukopenia, muscle cramps, nausea, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.

Average Dosage
One tablet (100 mg.) daily with breakfast.

Availability
Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

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How does Hygroton®
brand of chlorthalidone
stack up against other diuretics?

Not very high. In terms of one week's therapy, that is. The usual dosage is just one tablet per day. Very often, the dosage is even lower. So a week's therapy doesn't amount to much.

That's why it's nice to work with Hygroton®, brand of chlorthalidone. You have fewer tablets to prescribe. Your patients have fewer tablets to take. And fewer to pay for.

For sheer diuretic effectiveness, choose Hygroton®, brand of chlorthalidone. It generally promotes more natruresis per tablet than the thiazides. We'll stack it up against any diuretic

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Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

MARCH

6-7	KAGP Elizabethtown Seminar, Holiday Inn, Elizabethtown
15	11th Annual Senior Day, University of Louisville School of Medicine, Louisville
18	KMA Interim Meeting, Gabe's, Owensboro
29-Apr. 1	Kentucky Hospital Association Annual Meeting, Kentucky Hotel, Louisville
29-Apr. 2	Symposium on "Genito-Urinary Diseases," Radiology Department, University of Kentucky Medical Center, Lexington

APRIL

1-2	Kentucky OB-GYN Society Annual Meeting, Lexington
1	Lexington Clinic Conference, 8:30 a.m. to 4:30 p.m., Lexington Clinic, Lexington
3	"Professors Day," 9:00 a.m. to 3:00 p.m., University of Kentucky Medical Center, Lexington
4-7	Kentucky Dental Association Annual Meeting, Brown Hotel, Louisville
7, 14, 21, 28	Fourth Semiannual Postgraduate Course in "Psychiatry for Practicing Physicians," University of Louisville School of Medicine, course to be held at the Louisville Area Mental Health Center, 2:00-6:00 p.m., Louisville
7	KAGP Lake Cumberland State Park Seminar, Jamestown
8	Pediatrics, "Refresher Course," 8:00 a.m. to 5:00 p.m., University of Kentucky Medical Center, Lexington
9-10	Kentucky Chapter, American College of Surgeons Annual Meeting, Holiday Inn, Paducah
13	2nd Annual Senior Day, University of Kentucky Medical Center, Lexington
15	University Surgery Day, 12:00 to 5:00 p.m., University of Kentucky Medical Center, Lexington
22-23	Kentucky Thoracic Society, University of Kentucky Medical Center, Lexington
30	"Cardiology Night," 7:30 p.m. to 9:00 p.m., University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

FEBRUARY

25-March 2	American Dermatological Association, Boca Raton Hotel, Boca Raton, Florida

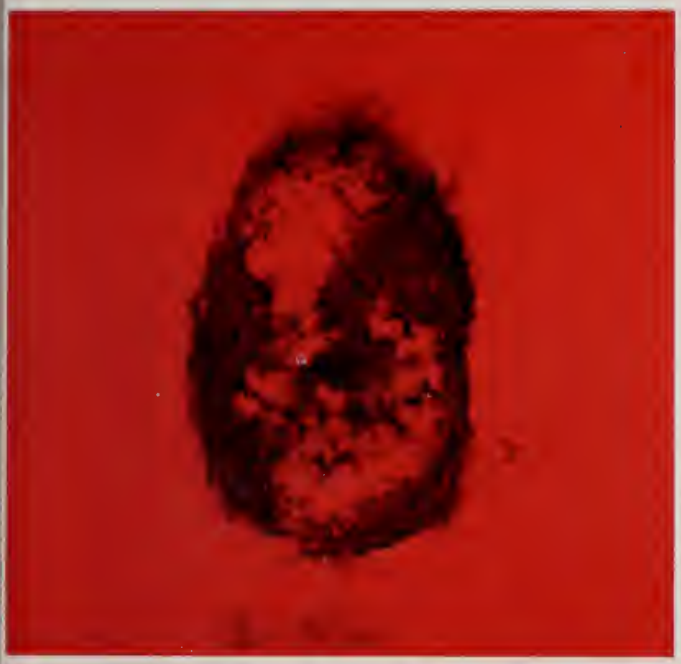
MARCH

7-10	International Academy of Pathology, Philadelphia Sheraton Hotel, Philadelphia, Pennsylvania
15-19	American College of Physicians, Postgraduate Course No. 11, Emory University School of Medicine, Atlanta
17-18	Postgraduate Course, "Advances in Urology," Cleveland Clinic, Cleveland, Ohio
19-21	American Society of Internal Medicine, Conrad Hilton Hotel, Chicago
22-26	American College of Surgeons, Chicago
24	Seventh Annual "Resident's Day" in Obstetrics and Gynecology, Wayne State University, Wayne County Medical Society Building, 1010 Antietam Street, Detroit, Michigan
26-27	National Conference on Rural Health, Americana Hotel, Miami Beach
29-Apr. 1	Southeastern Surgical Congress, Statler Hilton Hotel, Washington, D.C.
29-Apr. 10	Course in Laryngology and Bronchoesphagology, University of Illinois Medical Center, Chicago
31-Apr. 2	Symposium on "Gastroenterology," Medical College of Georgia, Augusta

APRIL

4-8	American College of OB-GYN, Civic Auditorium, San Francisco
5-8	Industrial Medical Association, Americana Hotel, Bal Harbour, Florida
11-14	Tennessee Medical Association, Read House, Chattanooga
12-16	American Academy of General Practice, Civic Auditorium, San Francisco

kills Haemophilus influenzae in respiratory infections



Electron micrograph of normal H. influenzae *organism.*



Electron micrograph of H. influenzae *after a 2-hour exposure to a therapeutic (8γ/ml.) dose of PENBRITIN (ampicillin).*

New broad-spectrum penicillin:

- most active antibiotic against *Haemophilus influenzae*[1-3]—a major pathogen in chronic bronchitis and respiratory infections in children
- demonstrated clinical efficacy and safety in chronic bronchitis[4-10]
- more effective than tetracycline in reducing sputum in chronic bronchitis[5]

Usual Adult Dosage: 250 mg. every six hours. *Usual Dosage for Children*—(under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours for moderately severe infections; 200 mg./Kg./day in divided doses every six hours for severe infections.

Contraindications: (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci or other penicillinase-producing organisms.

Side Effects: Mild effects, such as skin rashes, diarrhea, nausea and vomiting, have occasionally appeared.

Precautions: As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

Supplied: No. 606—Each capsule contains 250 mg. of ampicillin. Bottles of 16 and 100.

References: 1. Millard, F. J. C., and Batten, J. C.: Brit. M. J. *i*:1159 (April 28) 1962. 2. Ivler, D., *et al.:* Abstracts, Third Interscience Conference on Antimicrobial Agents and Chemotherapy, October 1963, p. 32. 3. Stewart, G. T.: Pharmakotherapia *1*:197, 1963. (Progress in Drug Therapy). 4. Grant, I. W. B., *et al.:* Brit. M. J. *ii*:482 (Aug. 18) 1962. 5. Millard, F. J. C., and Batten, J. C.: Brit. M. J. *i*:644 (March 9) 1963. 6. Oswald, N. C.: Postgrad. Med. *35*:233 (March) 1964. 7. Howells, C. H. L., and Tyler, L. E.: Brit. J. Clin. Pract. *17*:321 (June) 1963. 8. May, J. R., and Delves, D. M.: Thorax *19*:298, 1964. 9. May, J. R., *et al.:* Lancet *ii*:444 (Aug. 29) 1964. 10. Pines, A.: Lancet *ii*:445 (Aug. 29) 1964.

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KMA Council and Committee Reports

Council on Legislative Activities

John C. Quertermous, M.D., Chairman, National Affairs

James C. Cantrill, M.D., Chairman, State Affairs

KMA Headquarters Office **January 13, 1965**

The KMA Council on Legislative Activities held its first meeting of 1965 to discuss matters relating to the 89th Congress that convened in Washington on January 4, and other timely topics. AMA's field representative for Kentucky was present to discuss recent national developments.

The general discussion centered around the administration's new medicare bill and the recent AMA announcement of a "Comprehensive Health Care for the Aged" proposal. A report was given on the Kerr-Mills Conference held in Chicago on January 9 and 10, and preliminary plans for the 1965 Congressional Dinner were made. It was announced that there was to be a new education program in connection with the new AMA proposal and the King-Anderson bill.

Final plans were made for the Council's program to be presented at the Interim Meeting in Owensboro on March 18. The duties of district, sub-district and county key men were reviewed. KEMPAC's new officers were announced. Other matters relating to state affairs and the next session of the Kentucky Legislature were discussed.

Council on Communications and Public Service

N. Lewis Bosworth, M.D., Lexington, Chairman

KMA Headquarters Office **December 17, 1964**

The Council on Communications and Public Service held its first meeting and heard reports on its committees' activities and plans for the year from the committee chairmen. It was announced that the newly formed Orientation Committee would meet in the near future to plan the first KMA Orientation Program scheduled for Monday, September 20, just prior to the KMA Annual Meeting.

The Council members approved KMA exhibits for the Annual Meeting of the Kentucky Education Association in April and the Kentucky State Fair in September. The chairman reported that the AMA House of Delegates had authorized the installation of teletype communication equipment in state medical association headquarters offices. The Council will meet again later in the Associational year to prepare its final report to the KMA House of Delegates.

Council on Allied Professions and Related Groups

W. K. Massie, Jr., M.D., Lexington, Chairman

KMA Headquarters Office **January 7, 1965**

At its first meeting of this year, the Council on Allied Professions and Related Groups reviewed the 1964 reports of its various committees, discussed the duties of the committees, and proposed programs for the 1964-65 Associational year. The chairman announced that a Sub-Committee on Disability and Physical Impairment had been formed and would serve under this Council.

Most of the Council's committees have scheduled meetings for the year and the Council plans to meet again on July 1 to prepare its final report to the 1965 session of the KMA House of Delegates.

Retardation Unit Aide Named

Melville J. Appell, formerly of Bridgeport, Conn., became the new deputy commissioner for mental retardation, in the Kentucky Department of Mental Health, on January 15, it was recently announced.

In Bridgeport he was a consultant in vocational rehabilitation for the Board of Education and has served as an advisor to the President's Panel on Mental Retardation. He has served in mental health programs in Ohio, Pennsylvania, and New Jersey. A psychologist, he holds a masters degree from Teachers College, Columbia University.

Indiana Past President Dies

August P. Hauss, M.D., 75, New Albany, Ind. civic leader and a past president of the Indiana Medical Association, died December 30 at a New Albany Hospital. A general practitioner, Doctor Hauss was graduated from the University of Louisville School of Medicine in 1911. He began his medical practice in New Albany in 1914.

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Each tablet contains:			
ACHROMYCIN® Tetracycline HCl	125 mg.	Caffeine	30 mg.
Acetophenetidin (Phenacetin)	120 mg.	Salicylamide	150 mg.
		Chlorothen Citrate	25 mg.

Effective in controlling tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects are drowsiness (so one should not drive while on drug), slight gastric distress, overgrowth of nonsusceptible organisms. Tooth discoloration may occur if given during tooth formation (late pregnancy, the neonatal period, early childhood). Reduce dosage in impaired renal function. Increased intracranial pressure is a possible complication in infants. Average adult dosage: 2 tablets four times daily, given at least 1 hour before or 2 hours after meals.

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PLAN TO ATTEND
March 10 & 11, 1965

The Brown Hotel—Louisville, Kentucky

11th Annual Symposium On Cardiovascular Diseases

Wednesday, March 10, 1965

Morning Session: Presiding—ROBERT L. MCCLENDON, M.D., Chairman Symposium Committee, Assistant Clinical Professor of Medicine, University of Louisville School of Medicine, Louisville, Kentucky.

"Stress and Coronary Heart Disease": LAWRENCE E. HINKLE, JR., M.D., Associate Professor of Medicine; Associate Professor of Medicine in Psychiatry; and Director of the Division of Human Ecology of the Departments of Medicine and Psychiatry, Cornell University Medical College, New York, New York.

"Cardiac Trauma": DENTON A. COOLEY, M.D., Professor of Surgery, Baylor University College of Medicine; and Chief, Cardiovascular Surgery, Texas Children's Hospital, Houston, Texas.

"The Effects of Stress and Trauma on the Heart —Medical-Legal Considerations": JOHN V. THORNTON, Associate Dean, New York Law School; Adjunct Professor of Law and Lecturer on Legal Medicine, New York University, and Professional Lecturer on Law, St. John's University, New York, New York.

Panel on *"Stress and Trauma Affecting the Cardiovascular System"*: Moderator—J. MURRAY KINSMAN, M.D., Vice-President, University of Louisville, Louisville, Kentucky.

Luncheon Meeting: Speaker — HELEN B. TAUSSIG, M.D., Professor Emeritus of Pediatrics, Johns Hopkins University School of Medicine, Baltimore, Maryland; President-Elect, American Heart Association.

Afternoon Session: Presiding—JACK CHUMLEY, M.D., President, Heart Association of Louisville and Jefferson County; Associate in Medicine, University of Louisville School of Medicine, Louisville, Kentucky.

Bernard D. Rosenblum Memorial Lecture: *"Natural History of Congenital Heart Disease"* —HELEN B. TAUSSIG, M.D.

"Current Status of Surgical Treatment for Congenital Heart Disease": DENTON A. COOLEY, M.D.

"Pre-Operative and Post-Operative Complication in Anesthesiology": DUNCAN A. HOLADAY, M.D., Professor of Surgery (Anesthesiology); Head, Section of Anesthesiology, University of Chicago School of Medicine, Chicago, Illinois.

Panel on *"Discussion of Diagnostic Information Concerning Pre and Post-operative Complication Related to the Cardiovascular System"*: Moderator—DANIEL MAHAFFEY, M.D., Practicing Thoracic Surgeon, Louisville, Kentucky.

Thursday, March 11, 1965

Morning Session: Presiding—ROBERT S. DYER, M.D. Associate in Internal Medicine, University of Louisville School of Medicine, Louisville, Kentucky.

"Aldosterone, Hypertension and Edematous States": PETER J. TALSO, M.D., Professor and Chairman, Department of Medicine, Stritch School of Medicine, Loyola University, Chicago, Illinois.

"Hemodynamics of Heart Sounds": KAREEM MINHAS, M.D., Associate Professor of Pediatrics (Cardiology), University of Louisville School of Medicine; Director, Pediatric Cardiology, Children's Hospital and Director, Cardiac Care Program, Commission for Handicapped Children, Louisville, Kentucky.

"Cardiovascular Alterations in Toxemia of Pregnancy": ALLEN C. BARNES, M.D., Professor and Chairman of the Department of Gynecology and Obstetrics; Johns Hopkins University School of Medicine; Gynecologist-Obstetrician-in-Chief, The Johns Hopkins Hospital, Baltimore, Maryland.

Panel on *"Diagnostic and Therapeutic Manifestations of Abnormalities in the Cardiovascular System"*: Moderator—BEVERLY T. TOWERY, M.D., Professor and Chairman, Department of Medicine, University of Louisville School of Medicine, Louisville, Kentucky.

Afternoon Session: Presiding — JOHN S. LLEWELLYN, M.D., Instructor in Medicine, University of Louisville School of Medicine, Louisville, Kentucky.

"Cardiac Involvement in Collagen Diseases": LEON SOKOLOFF, M.D., Chief of Section on Rheumatic Diseases, Experimental Pathology Laboratory, National Institute of Arthritis and Metabolic Diseases, National Institutes of Health, Bethesda, Maryland.

"Cardio-renal Syndromes": LEONARD B. BERMAN, M.D., Associate Professor of Medicine; Chief of Section on Nephrology, University of Louisville School of Medicine, Louisville, Kentucky.

"Clinical Pathological Conference": Moderator —LEON SOKOLOFF, M.D.

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Perryville Site Being Restored

The former office and apothecary shop of the late J. T. Polk, M.D., Civil War-era Perryville physician, has been deeded to the city of Perryville for restoration as an historical project. Mr. George Grider, Danville pharmacist and member of the KMA McDowell Home Committee, is in charge of refurnishing the building. Mr. Grider has requested persons having original furnishings and equipment belonging to Doctor Polk to lend these items for use in the office and apothecary.

Ophthalmology at U. of L.

Continued from Page 115

the Lions diagnostic clinic, and laboratories. The basement will house machine, electronic and woodworking shops plus photographic facilities.

The building will be structured to support additional floors to accommodate hospital facilities, if these become desirable.

Presently, 87,000 square feet of land at Walnut and Madison Streets are reserved by Urban Renewal at a valuation of $225,000 for this use. Construction funds are pegged below $1,000,000, and the Lions are now organizing a capital drive. Construction is to begin in 1966 and occupancy in 1968.

Active and close cooperation of university officers, volunteers faculty, and full-time personnel have developed ophthalmology to a major unit of the medical school. Further growth and contributions in teaching, care and research are inevitable.

Pertinent Paragraphs

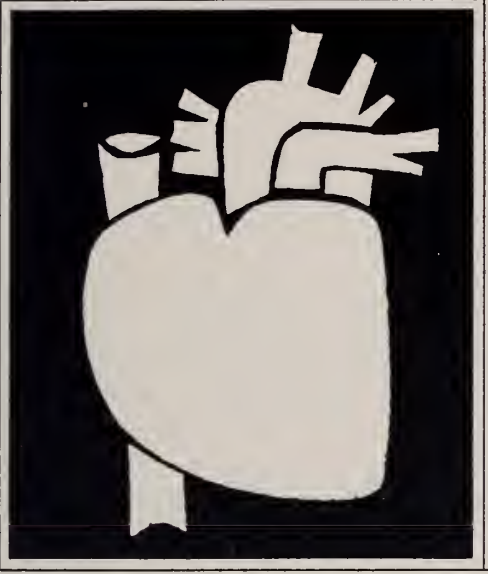
"Advances in Urology" will be the topic of the March 1 Cleveland Clinic Educational Foundation postgraduate course to be presented at the Clinic in Cleveland, O. Acceptances wil be made in the order of application. The fee for the course is $30. For application and further information write Education Secretary, The Cleveland Clinic Education Foundation, 2020 East 93rd Street, Cleveland, O., 44106.

A continuing medical education symposium on Gastro-enterology will be presented March 31-April 2 at the Medical College of Georgia at Augusta. The medical and surgical approach to problems in Gastroenterology will be discussed. For program information write to the Department of Continuing Education, Medical College of Georgia, Augusta, Ga.



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prophylaxis of pain in angina pectoris

Indications: 'Miltrate' is useful for prophylaxis of pain in angina pectoris and coronary insufficiency, especially where anxiety is a factor. **Contraindications:** Like all nitrates, pentaerythritol tetranitrate should be avoided or prescribed cautiously for patients with glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. **Precautions:** *Meprobamate* — Patients engaged in activities requiring alertness should be warned of drowsiness. Meprobamate may increase the effects of excessive alcohol, and the possibility of dependence should be considered, particularly in patients with a history of drug or alcohol addiction. Sudden withdrawal may result in reactions, rarely epileptiform seizures. Grand mal attacks may be precipitated in persons susceptible to both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies. **Side effects:** *Pentaerythritol tetranitrate* — The most common side effects are transient headache, nausea, and rash. Weakness, palpitation, flushing, gastrointestinal distress, and lightheadedness have been reported on a few occasions. *Meprobamate* — May cause drowsiness and, rarely, ataxia, usually controlled by decreasing the dosage. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses of the drug. Mild reactions include urticarial or maculopapular rash. Serious reactions, rarely encountered, include dermatological effects, acute nonthrombocytopenic purpura, chills, fever, fainting spells, angioneurotic edema, bronchial spasm, hypotensive crisis, anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic, and the drug not be reinstituted. **Dosage:** Usual dosage is one or two tablets before meals and at bedtime. Individualization of dosage is required for maximum therapeutic effect. Doses above twelve tablets daily are not recommended. **Supplied:** White tablets, each containing meprobamate 200 mg. and pentaerythritol tetranitrate 10 mg. ***Before prescribing, consult package circular.***

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COUNTY SOCIETY REPORTS

Ballard

Glenn D. Baird, M.D., Bandana, will serve the Ballard County Medical Society as its president for 1965, according to the secretary, J. M. Hunt, M.D., of Wickliffe. Doctor Baird will be the Society's delegate to the KMA House of Delegates, and Doctor Hunt will serve as alternate delegate.

Bell

Frank T. Smith, M.D., Middlesboro, was elected 1965 president of the Bell County Medical Society at its December 11 meeting in Pineville. Robert B. Cloar, M.D., Middlesboro, will serve as secretary-treasurer.

Boone

Howard Ravenscraft, M.D., Hebron, is the new president of the Boone County Medical Society. He and the following new officers were installed January 9: Philip Schworer, M.D., Florence, vice-president; and James Schrand, M.D., Florence, Secretary; and William M. Waller, M.D., Walton, treasurer.

L. C. Hess, M.D., Florence, will be the Society's delegate to KMA.

Boyd

J. S. Wheeler, M.D., Ashland, took office in December as 1965 president of the Boyd County Medical Society. Doctor Wheeler will be aided in his work by Charles A. Webb, M.D., vice-president; Max E. Wheeler, M.D., treasurer; and Gerald B. Reams, M.D., secretary.

Rex Duff, M.D., J. E. Stephenson, M.D., and John Ashworth, MD.., will serve as delegates to KMA. Alternate delegates are E. W. Connelly, M.D., H. E. Martin, M.D., and Eugene Slusher, M.D., All the officers are from Ashland.

Bracken

Carl A. Marquardt, M.D., Augusta, was recently elected new president of the Bracken County Medical Society. J. M. Stevenson, M.D., Brooksville, will serve as vice-president and delegate to KMA, and D. E. Cummins, M.D., Brooksville, is secretary-treasurer.

Bullitt

R. Stephen Bowen, M.D., Mt. Washington, has been elected president of the Bullitt County Medical Society, according to a recent report. Doctor Bowen will be assisted in his duties by the secretary, J. W. Roney, M. D., Lebanon Junction. Doctor Bowen will serve as delegate to the KMA and Doctor Roney as alternate. Both took office January 1.

Butler

John C. Burris, M.D., Morgantown, is the new president of the Butler County Medical Society, it was reported recently. Also serving this year be D. G. Miller, M.D., Morgantown, secretary-treasurer. Doctors Burris and Miller will serve as delegate and alternate, respectively, to the 1965 KMA House of Delegates.

Fayette

T. R. Bryant, Jr., M.D., was installed in January as president of the Fayette County Medical Society, and I. F. Kanner, M.D., was named president-elect. Other officers installed at that time were David A. Hull, M.D., vice-president, and J. F. Berry, Jr., M.D., secretary-treasurer. All the officers are from Lexington.

Garrard

Paul E. Lett, M.D., Lancaster, will head the Gerrard County Medical Society in 1965. Also taking office for 1964-65 terms were O. S. Playforth, M.D., vice-president, and Paul J. Sides, M.D., secretary-treasurer. All are from Lancaster. Doctor Playforth will serve as delegate ot the KMA and Doctor Lett as alternate.

Henry

Shelby Hicks, M.D., New Castle, will serve as president of the Henry County Medical Society for 1965. Other new officers are: S. B. May, M.D., Eminence, vice-president; G. E. McMann, M.D., Eminence, secretary-treasurer; Doctor Hicks, delegate to KMA; and R. L. Houston, M.D., Eminence, alternate delegate.

Hickman

V. A. Jackson, M.D., is the new president of the Hickman County Medical Society, effective January 1. Also elected to serve in 1965 are Clarence J. Mills, M.D., vice-president; and Horace E. Titsworth, M.D., secretary-treasurer. Doctor Jackson will be the county's delegate to KMA, and Doctor Titsworth will serve as alternate delegate. All are from Clinton.

Jefferson

Roy H. Moore, Jr., M.D., Louisville, was installed January 18 as president of the Jefferson County Medical Society. Hoyt D. Gardner, M.D., Louisville, was chosen to serve as president-elect.

Also elected were the following officers: Robert S. Tillett, M.D., first vice-president; Harold G. Eskind, M.D., second vice-president; Ellis A. Fuller, Jr., M.D., secretary; and Frank A. Bechtel, M.D., treasurer. All are from Louisville.

Knox

R. E. Hayden, M.D., took office January 1 as new president of the Knox County Medical Society, according to a recent announcement. Other new officers are Harold L. Bushey, M.D., vice-president; and T. R. Davis, M.D., secretary-treasurer. Doctor Bushey was named delegate to KMA and Doctor Davis as alternate.

Marion

Robert H. Wilber, M.D., Lebanon, took office January 1 as president of the Marion County Medical Society, it was recently reported. Robert D. Eastridge, M.D., Lebanon, will serve as secretary-treasurer. David D. Drye, M.D., Bradfordsville, is the delegate to KMA, and Doctor Wilber will serve as alternate delegate.

McCracken

J. B. Spaulding, M.D., was elected December 16 as new president of the McCracken County Medical Society. Also elected at that time were: James C. Embry, Jr., M.D., vice-president; and Frank B. Crawford, M.D., secretary-treasurer. Delegates to KMA will be James A. Harris, M.D., William B. Haley, M.D., and R. M. Wooldridge, M.D. Alternate delegates are Walter R. Johnson, M.D., C. W. Raymond, M.D., and Charles B. Billington, M.D. All are from Paducah.

McCracken

The regular meeting of the McCracken County Medical Society was held November 18 at Boswell's Restaurant in Paducah.

John M. Trawick, M.D., associate professor of psychiatry at the University of Louisville School of Medicine delivered an address on "Depression" as the scientific program for the evening. An interesting discussion followed.

There being no further business the meeting adjourned at 9:00.

Mercer

George F. Ballard, M.D., has been elected president of the Mercer County Medical Society. Also serving for the 1965 year will be Bacon R. Moore, III, M.D., vice-president, and C. B. Van Arsdall, Jr., M.D., secretary-treasurer. J. S. Baughman, M.D., will be delegate to KMA and Ballard will serve as alternate. All the officers are from Harrodsburg.

Shelby-Oldham-Henry

J. T. Walsh, M.D., LaGrange, was recently elected president of the Shelby-Oldham-Henry County Medical Society. Serving as officers with Doctor Walsh will be: E. G. McMunn, M.D., Eminence, vice-president and president-elect; and C. C. Risk, D.D.S., Shelbyville, secretary-treasurer; Willis P. McKee, M. D., Shelbyville, delegate to KMA; and Don Chatham, M.D., alternate delegate.

Webster

William W. Wainer, M.D., Providence, was elected December 15 to serve as 1965 president of the Webster County Medical Society. Doctor Wainer will be assisted in his executive duties by the following: Earl W. Atherton, M.D., Clay, vice-president; Paul M. Taylor, Providence, secretary-treasurer; and John A. Logan, III, M.D., Sebree, delegate to KMA.

Whitley

Lawrence U. Gilliam, M.D., Corbin, will be president of the Whitley County Medical Society for 1965, it was recently announced. Doctor Gilliam will be assisted in office by: R. D. Pitman, M.D., Williamsburg, vice-president; Raymond Ohler, M.D., Corbin, secretary-treasurer; Harold Barton, M.D., Corbin, delegate to KMA; and Willard Buttermore, M.D., Corbin, alternate delegate.

In Memoriam

HENRY C. BLOUNT, M.D.
Cynthiana, Ky.
1880 - 1964

Henry C. Blount, M.D., 84, retired Cynthiana physician, died December 2 of heart failure following a minor automobile accident. A 1906 graduate of the Medical Department of the University of Louisville, Doctor Blount had practiced in Cynthiana until his retirement a short time ago.

GROVER HENDRICK ROSS, M.D.
Stamping Ground, Ky.
1884 - 1964

Grover H. Ross, M.D., retired Scott County general practitioner and banker, died December 4 at his home at Stamping Ground after a brief illness. Doctor Ross graduated from the University of Louisville School of Medicine in 1909 and had practiced at Berry for 55 years. He was president of the Union Bank at Berry for more than 40 years.

ADOLPHUS D. BUTTERWORTH, M.D.
Murray, Ky.
1892-1965

Adolphus D. Butterworth, M.D., 72, Murray general practitioner and surgeon, died January 1 following an illness of several months. Doctor Butterworth retired from private practice in 1960, at which time he became Public Health Officer for Calloway County. He was a 1926 graduate of the Medical Departmen tof Vanderbilt University and had practiced in Murray since 1933.

KARL DAVID WINTER, M.D.
(Formerly) Louisville, Ky.
1892 - 1964

Karl D. Winter, M.D., a general surgeon in Louisville for more than 45 years before his retirement, died December 21 at Gulfport, Miss. Doctor Winter, 72, had lived at Pass Christian, Miss., for two years. He graduated in 1915 from the University of Louisville School of Medicine. Doctor Winter was a veteran of World War 1, an emeritus member of the Kentucky Medical Association, and was a member of a number of other medical organizations.

GERALD GREENFIELD, M.D.
Louisville, Ky.
1920 - 1965

Gerald Greenfield, M.D., 44, Louisville internist, died January 13 in Louisville as the result of a heart condition. Doctor Greenfield, former president of the Jewish Hospital Medical Staff, graduated in 1944 from the University of Louisville School of Medicine. He was a native of New York.

PHILLIP D. BRIGGS, M.D.
Louisville, Ky.
1922 - 1965

Phillip D. Briggs, MD.., died January 13 in Louisville following surgery. Death was attributed to a heart attack. Doctor Briggs, 42, a native of Hickman, had practiced in Louisville since his graduation from the University of Louisville School of Medicine in 1951. He was a veteran of World War II.

ELLEN LICHTENSTEIN, M.D.
Louisville, Ky.
1899 - 1964

Ellen Lichtenstein, M.D., 65, chief of mental hygiene for the Veterans' Administration Regional Office in Louisville, died December 6 in Louisville. Doctor Lichtenstein, a psychiatrist, had been associated with Western State Hospital at Hopkinsville before coming to Louisville last March. Born and educated in Germany, Doctor Lichtenstein came to this country before World War II and was a naturalized citizen.

McCormack Award Presented

The McCormack Award, established in 1950, was presented to Carl N. Neupert, M.D., of Wisconsin, and G. St. Peeples, South Carolina, both health officers, by the Association of State and Territorial Health Officers at its annual conference in Washington in November. The award is named in honor of the late Arthur T. McCormack, M.D., Kentucky health commissioner from 1912 to 1947.

* * *

The American Academy of Physical Medicine and Rehabilitation will hold its annual meeting August 22-27, 1965, at the Sheration Hotel in Philadelphia. The program will consist of formal lectures, as well as educational seminars in the field of Hypertonia, Hypotonia, and Forensic Physiatry (Workmen's Compensation.)

Four new training programs primarily directed toward the pediatrician are now being offered at the University of California School of Public Health at Berkeley. The programs are: "Basic Training in Maternal and Child Health," "Training in Mental Retardation," "Training in School Health," and a combined training course in Maternal and Child Health and Pediatrics. For further information write to the School of Public Health, Maternal and Child Health, University of California, Berkeley, Calif., 94720.

Of great importance to the public at large, physicians and the drug industry is the increasingly heavy hand of restrictions being laid upon the pharmaceutical industry. The question is not a matter of whether certain rules and regulations ought to be followed in the testing and marketing of drugs, but how strict should they be. Or to put it another way—how "extreme" should such directives be—very mild and loose (ultra-right?) or very tight and restrictive (ultra-left?).—Joseph P. Schaefer, M.D., in *New Physician*, 13: 10, (Oct.) 1964.

As the new drug is being introduced on the market and becomes generally available, the pharmaceutical manufacturer loses his tight control over its use, and a major part of the responsibility for the judicious application of the compound now rests with the medical profession and the scientific organizations and societies interested in drug therapy. It is therefore hoped that the many local, national, and international organizations which are concerned with effects and adverse reactions of drugs will join with the pharmaceutical manufacturer and the government agencies charged with surveillance of drugs in an effort to assure the most beneficial and the safest application of our modern chemical weapons against disease.—Gerhard Zbinden, M.D., in *Clinical Pharmacology and Therapeutics*, 5: 5, (Sept.-Oct.) 1964.

In recent years, several medical schools have established centers for training clinical pharmacologists, and the Pharmaceutical Manufacturers Association and some of the leading pharmaceutical companies have made substantial grants for the support of such training programs. It is harder to define a clinical investigator. but I believe that most people would agree that a clinical investigator is a physician who has had some residency training in one of the clinical specialties, has some knowledge beyond the undergraduate curriculum of one or more of the basic sciences, and who seeks in his research to explain human disease with the help of those basic sciences. Harry F. Dowling, M.D. in *J.A.M.A.*, 187:3 (Jan. 18) 1964.

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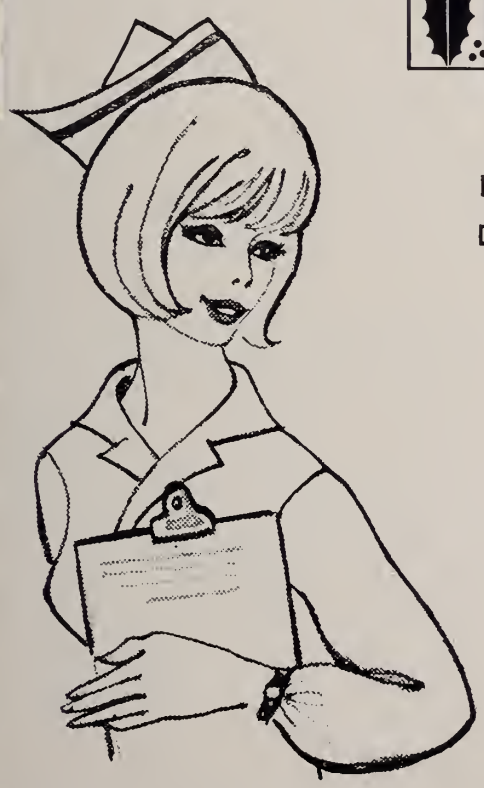
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STUDY OF MATERNAL MORTALITY



Annual Report†

TABLES 1 and 1a—Maternal Deaths by Occurrence and Calar, With Rates

	From Biastatistics						Fram Committee Study					
	Total		White		Nan-White		Total		White		Non-White	
Year	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate
1962	29	4.1	22	3.4	7	11.2	42	5.9	30	4.6	12	19.2
1961	40	5.5	28	4.2	12	18.7	50	6.8	35	5.3	15	23.4
1960	29	3.9	27	4.0	2	3.1	41	5.6	36	5.4	5	7.8

TABLE 2—Maternal Deaths by Occurrence, Indicating thase Delivered and those nat Delivered, with Place af Delivery far thase Delivered, with Rates, and Place of Death for those nat Delivered, fram Biostatics.

			Delivered					No Delivery		
	Total		Haspital		Other		Nat Stated	Hasp.	Other	Nat Stated
Year	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Deaths	Deaths	Deaths
1962	29	4.1	22	3.3	4	10.5	—	2	1	—
1961	40	5.5	29	4.2	8	18.9	—	2	1	—
1960	29	3.9	20	2.9	7	15.1	—	2	—	—

TABLE 2a—Maternal Deaths, by Occurrence, Indicating those Delivered and those not Delivered, with Place af Delivery far thase Delivered, with Rates, and Place af Death far thase nat Delivered, from Cammittee Study

			Delivered					No Delivery		
	Total		Haspital		Other		Nat Stated	Hasp.	Other	Nat Stated
Year	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Deaths	Deaths	Deaths
1962	42	5.9	35	5.2	4	10.5	—	2	1	—
1961	50	6.8	37	5.4	8	18.9	—	3	1	1
1960	41	5.6	30	4.3	7	15.1	1	3	—	—

TABLE 4—Maternal Deaths, by Occurrence, Fram Biastatistics

	1962		1961		1960	
Cause						
Total Maternal Deaths	29	100.0	40	100.0	29	100.0
Sepsis of preg. and puerperium	5	17.2	6	15.0	—	—
Toxemias af preg. and p.p.	6	20.7	12	30.0	1	3.5
Hemorrhage	4	13.8	10	25.0	9	31.0
Abortion with sepsis	2	6.9	2	5.0	2	6.9
Abortian withaut mention af sepsis	2	6.9	1	2.5	4	13.8
Other complications	10	34.5	9	22.5	13	44.8

TABLE 4a—Maternal Deaths, by Occurrence as reviewed by Maternal Mortality Committee

	1962		1961		1960	
Cause	Deaths	Percent	Deaths	Percent	Deaths	Percent
Total Maternal Deaths	42	100.0	50	100.0	41	100.0
Sepsis of pregnancy, preg. & p.p.	5	11.9	6	12.0	—	—
Toxemias of preg. & p.p.	6	14.2	12	24.0	1	2.4
Hemorrhage	4	9.5	10	20.0	9	22.0
Abartion with sepsis	2	4.8	2	4.0	2	4.9
Abortion withaut mention of sepsis	2	4.8	1	2.0	4	9.7
Other camplications	23	54.8	19	38.0	25	61.0

TABLES 5 and 5a—Maternal Deaths, by Occurrence, by Parity, with Rates

	From Biostatistics						From Cammittee Study					
	1962		1961		1960		1962		1961		1960	
Parity	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate
Total	29	4.1	40	5.6	29	3.9	42	5.9	50	6.8	41	5.6
0	4	2.2	9	4.8	1	0.5	5	2.7	11	5.9	4	2.2
1-3	7	1.9	13	3.5	8	2.1	13	3.6	15	4.0	12	3.2
4-6	8	7.3	10	9.1	6	5.3	8	7.3	15	13.7	10	8.9
7 & Over	2	4.5	1	2.2	9	19.9	3	6.7	2	4.4	9	19.9
Not Stated	8	*	7	*	5	*	13	*	7	*	6	*

†*This is a continuation of the Maternal Mortality report contained in the December, 1964 Journal.*

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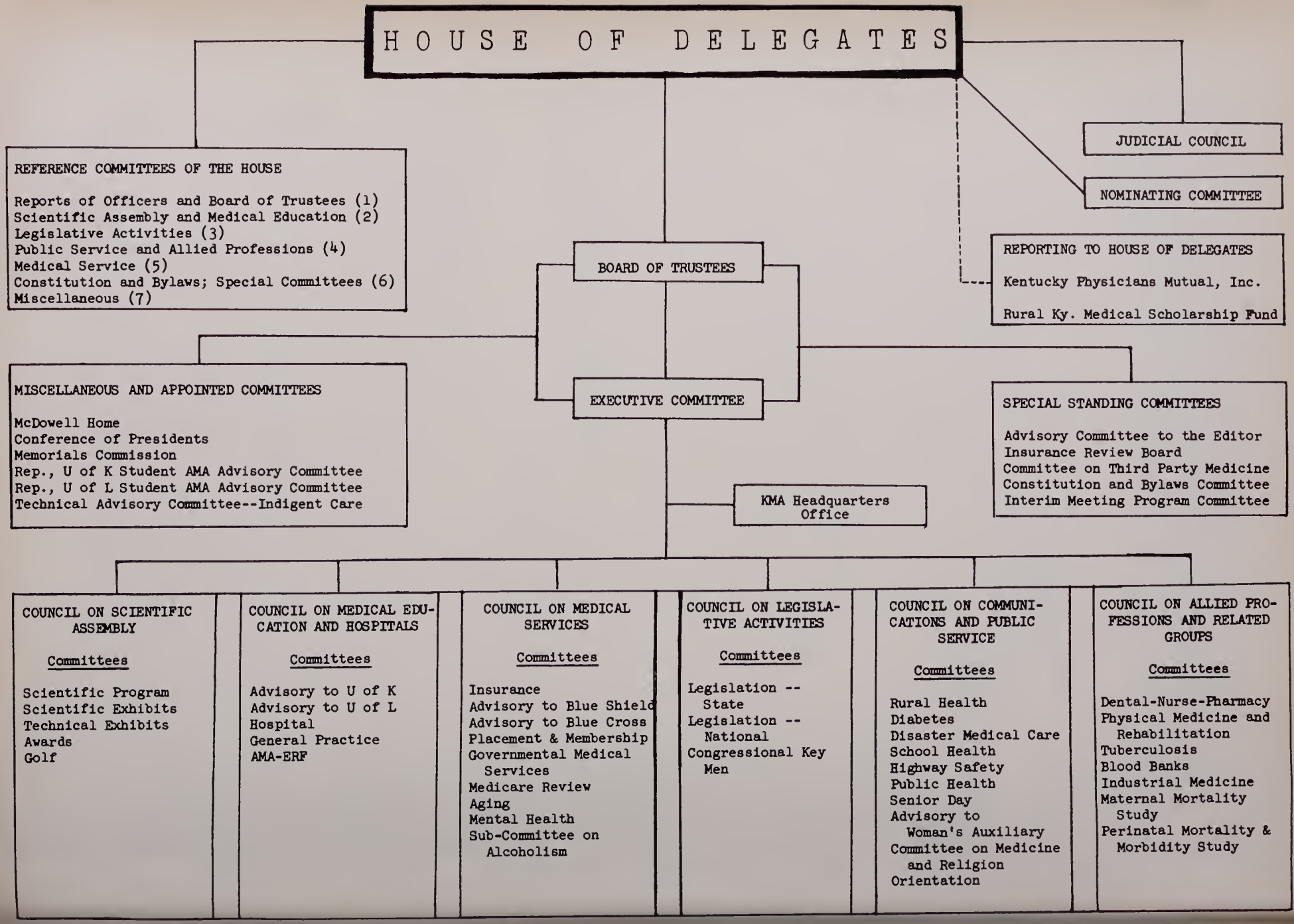
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REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953. 2. Cohen, et al.: J.A.M.A., 165:225, 1957.

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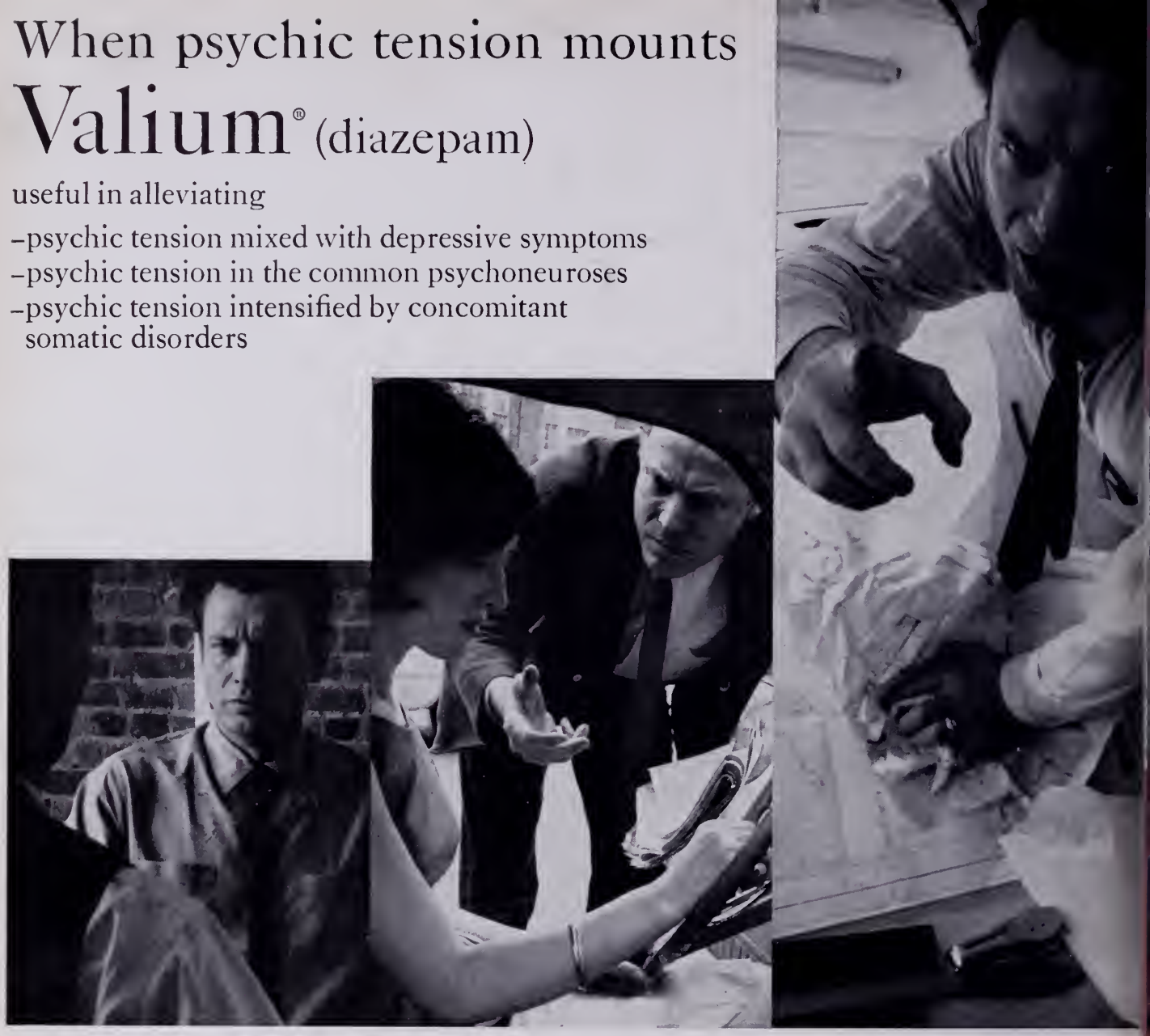
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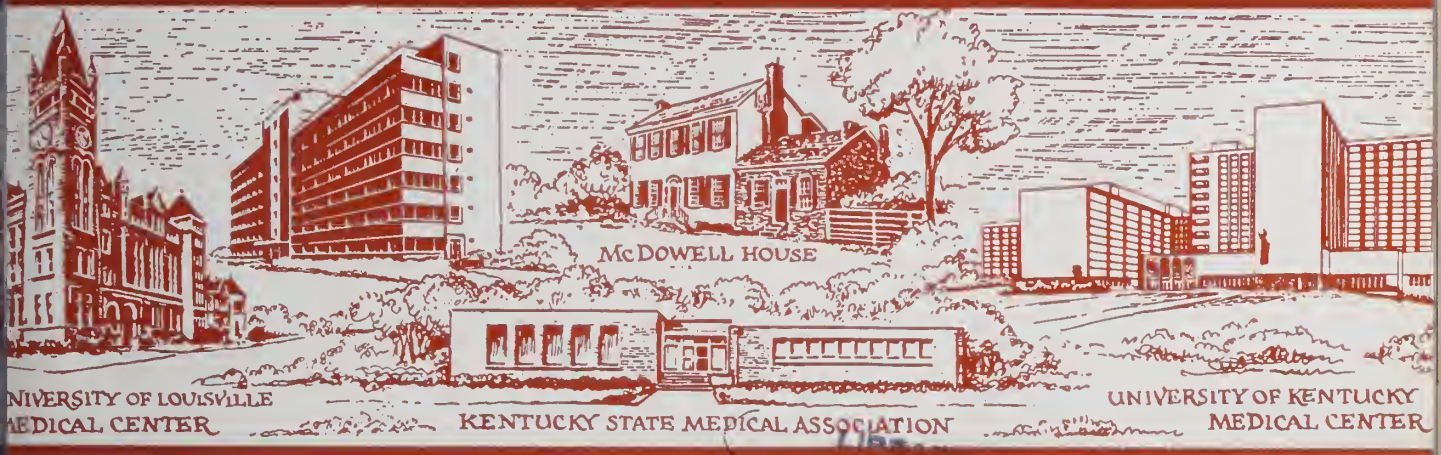
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*Lennox, W. G.: Epilepsy and Related Disorders, Boston, Little, Brown and Company, 1960, vol. 2, p. 865.

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MESSAGE FROM THE PRESIDENT



A Moonshot in Central Kentucky

ON January 21, 1965, a previously launched project of the University of Louisville landed safely on its target area in the name of the *University of Louisville Medical Center*. The impact of this project, the launch and landing sites, will endure for generations to advance medical education, research, skill and knowledge for the information and treatment of disease. It is a noble, bold, and thoughtful vision for the people of our Commonwealth.

Kentucky has always been deserving of the benefits of the science and art of medicine and allied health facilities, and has, until now, met this challenge to provide and make available this previous service. Early in our history the problem was identified and a solution indicated to insure continuous progress.

Our great society and any thereafter, will need to re-identify similar problems and propose solutions. The Commonwealth took the Jetstream toward these ideals in establishing a University of Kentucky Medical Center in Lexington a scant six years ago. Many said Kentucky did not need and could neither afford nor support two medical centers. Quite the obverse has been proven.

Skeptics are rarely pleased with progress. They want status quo. It takes ideals and vision to win the war against disease. Many features of this current project are dependent on the Commonwealth to help match funds with national and local governments to make this education, training, and research facility a reality for all our citizens and neighbors.

The bond issue is our local moonshot. The responsibility is here. It is present because problems have been identified which we have created ourselves. The solution is proposed; the implementation is ours to promote and culminate as a free, informed and great society. All Kentuckians will benefit and be proud. Let us be ever mindful of our motto "United We Stand — Divided We Fall". The bond issue this fall needs your support to fulfill our obligation for the future of Kentucky.

ROBERT W. LYKINS, M.D.
VICE PRESIDENT (CENTRAL)

** This is the second in a series of guest articles written at the request of KMA president Delmas M. Clardy, M.D. for this page by the three KMA vice presidents and the president of the KMA Woman's Auxiliary.*



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1. Clinical report on file, Medical Department, A. H. Robins Co., Inc.
2. Schiller, I. W. and Lowell, F. C.: New England J. Med. 261:478, 1959.

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NUMBER 3 IN A SERIES

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BRIEF SUMMARY

INDICATIONS: In addition to its primary indications for duodenal and gastric ulcer, glycopyrrolate is indicated for other G-I conditions which may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

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PRECAUTIONS: Administer with caution in the presence of incipient glaucoma.

SIDE EFFECTS: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

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REFERENCES: 1. Epstein, J. H.: Am. J. of Gastroent., 37:295, March, 1962. 2. Breidenbach, W. C.: Investigative Clinical Report, March, 1961. 3. Young, R., and Sun, D. C. H.: Ann. N. Y. Acad. Sc., 99:174, Feb., 1962. 4 Slanger, A.: Journal of New Drugs, 2:215, July-Aug., 1962. 5. Posey, E. L., Jr.: Am. J. Dig. Dis., 7:863, Oct., 1962.

PUBLIC HEALTH PAGE

New RH and Atypical Antibody Testing Program For Prenatal Patients*

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health, Commonwealth of Kentucky

A NEW Rh antibody testing program has been instituted through the Division of Maternal and Child Health at the central laboratory of the State Health Department in Frankfort. Up to now, Rh testing at the state laboratory has been limited to simple determination of whether a patient is Rh positive or Rh negative (D+ determination). No Rh antibody determination or serial antibody titer testing has been done in the past.

Since the discovery of the Rh factor in 1940 and subsequent finding of the abnormal Rh antibodies in the serum of some pregnant patients, testing for abnormal antibodies and serial antibody titer determinations has been widely used to detect Rh incompatibility between the pregnant patient and her husband. The presence of abnormal antibodies in the serum of a pregnant patient can lead to a serious complication in the infant known as hemolytic disease of the newborn. Such an infant, if not stillborn, may be born with hydrops fetalis (a massive edema usually resulting in death) or kernicterus (the staining of a particular portion of the brain, resulting in death or extreme neurological involvement of the infant, and mental retardation).

In the years since the discovery of the Rh factor, studies in the field of immunohematology in the pregnant patient have shown that the presence of other "atypical antibodies" in the serum of the pregnant patient can produce hemolytic disease in the newborn infant. (The Rh antibody, however, is by far the more common offender.) In many of these cases the mother is Rh positive and thus there is no suspicion of hemolytic disease prior to delivery. In recent years the Rh antibody titer determination has proven to be of doubtful efficacy in a significant percentage of cases and more and more articles in the obstetrical literature question the efficacy of Rh antibody titer determinations altogether. This is due to the fact that in a significant percentage of the cases there is no correlation between antibody titer reports, clinical history, and outcome of pregnancy in the infant. This has led many investigators and clinicians to adopt some of the newer methods of testing for abnormal or atypical antibodies, and to do titers only in selected patients. The use of selected groups or "pools" of human red cells containing most all of the significant red cell antigens has proven to be of great value in detecting 99+ per cent of all known clinically significant antibodies, of which the Rh is the most common.

The new Rh testing program at the State Public Health Laboratory will utilize commercially available pooled human red cells in two "screening panels" that will detect 99+ per cent of all known clinically significant antibodies in the serum of the pregnant patient.

In implementing this new program the following points should be brought to your attention:

(1) All prenatal blood samples will be subjected to this new screening test for "atypical antibodies" regardless of whether they are Rh positive or negative.

(2) Testing for D+ (Rh positive or negative) will continue as before and a test for "false negatives" will be routine on all prenatal blood specimens submitted for Rh determination.

(3) No Rh antibody titers will be done on these speciments at the state laboratory.

(4) Reporting will simply be for the presence or absence of "atypical antibodies" (most commonly Rh), the type of antibody, if any, found, and whether the patient is Rh positive or negative.

(5) Collection and mailing of blood speciments for determination will be the same as in the past for the old Rh program.

(6) *Practicing physicians* can obtain request forms and specimen vials from the local health department and mail the specimens directly to the State Public Health Laboratory in Frankfort.

(7) Upon receiving a report of "atypical antibodies present" and the type found, the local physician, the health officer, or health department clinician can decide upon the proper disposition of the patient involved. If the local physician decides to do antibody titers, this will have to be done through a private or hospital laboratory.

(8) All reports of *"atypical antibodies detected"* will be returned along with the patient's serum. At the physician's descretion, this serum can be sent to the hospital where the patient is to deliver to be used to properly set up blood for possible exchange trans-

(Continued on Page 224)

**This article was prepared by Robert S. Bain, M.D., Director Maternal, Infant and Preschool Services Kentucky State Health Department Frankfort, Kentucky*

the problem: diabetic . . . overweight . . . unresponsive to diet alone

the answer: ". . . if dietary control seems to be unsatisfactory . . . [and] if the patient is overweight . . . our first choice is phenformin [DBI] since this is the only oral hypoglycemic agent commercially available at present which does not promote fat deposit."[1]

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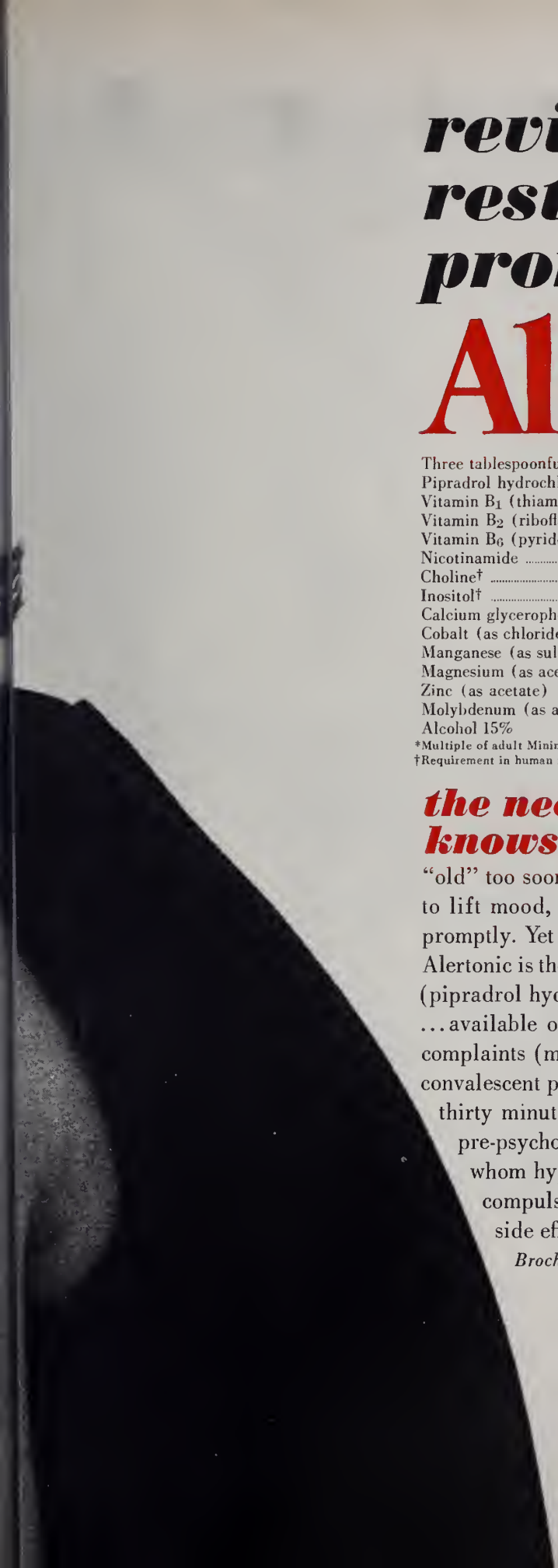
ide effects: Gastrointestinal, occurring more often at higher dosage evels, abate promptly upon dosage reduction or temporary withdrawal. recautions: Occasionally an insulin-dependent patient will show "star- ation" ketosis (acetonuria without hyperglycemia) which must be ifferentiated from "insulin-lack" ketosis which is accompanied by cidosis, and treated accordingly. Lactic acidosis has been reported in ondiabetics and diabetics treated with insulin, with diet, and with DBI. uestion has arisen regarding possible contribution of DBI to lactic cidosis in patients with renal impairment and azotemia and also those ith severe hypotension secondary to myocardial or bowel infarction. eriodic B.U.N. determinations should be made when DBI is adminis- ered in the presence of chronic renal disease. DBI should not be used hen there is significant azotemia. Any cardiovascular lesion that could esult in severe or sustained hypotension, which may itself lead to development of lactic acidosis, should be considered cause for immediate discontinuation of DBI at least until normal blood pressure has been restored and is maintained without vasopressors. Should lactic acidosis occur from any cause, vigorous attempts should be made to correct circulatory collapse, tissue hypoxia, and pH. **contraindications:** Severe hepatic disease, renal disease with uremia, cardiovascular collapse. Not recommended without insulin in acute complications of diabetes (metabolic acidosis, coma, severe infections, gangrene, surgery). **pregnancy warning:** *During pregnancy, until safety is proved, use of DBI, like other oral hypoglycemic drugs, is to be avoided.* Consult product brochure for full information.

1. Faludi, G.: J. Am. Med. Women's Assoc. 18:722, 1963. 2. Weller, C. et al.: Scientific Exhibit, A.M.A., June, 1962. 3 Moss, J. M. et al.: Medical Times 92:645, 1964.

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*A.M.A. Council on Drugs: J.A.M.A.183:469 (Feb. 9) 1963.

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1. Griffith, R.S., and Black, H.R.: Current Ther. Res., *6*: 253, 1964.

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The JOURNAL of the
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ISSUED MONTHLY UNDER THE DIRECTION OF THE BOARD OF TRUSTEES

VOLUME 63 March, 1965 No.3

Temporary Tube Gastrostomy †

J. HERMAN MAHAFFEY, M.D.
Louisville, Ky.

Temporary tube gastrostomy is an effective method to keep the stomach and intestine decompressed when prolonged postoperative ileus is anticipated.

FOLLOWING the reports of others regarding the advantages of temporary tube gastrostomy over prolonged nasogastric suction, I began in 1958 to utilize the procedure in those major abdominal operations in which postoperative adynamic ileus of more than thirty-six hours' duration might be anticipated.

Lengthy nasogastric suction in the postoperative patient is not infrequently associated with increased pulmonary complications. Increased salivation occurs because of pharyngeal irritation, discomfort to the patient is often considerable, coughing is impaired, and the tube, if not adequately irrigated and cared for, functions poorly. Gillesby and Puestow[4] demonstrated clinically that nasogastric intubation activates the esophago-salivary reflex, showing that it accounts for some 750 cc. per 24 hours extra secretion because of irritation. This was accomplished by measuring the output from the gastrostomy for twenty-four hours as a control, and then inserting a Levine tube with a resulting increase of 240 to 320 per cent in the fluid output from the gastrostomy.

The increased complaint of "heartburn" has been noted more in patients with a nasogastric tube in place than in those with a tube gastrostomy.[4] Reflux of gastric juice along the nasogastric tube can extend for distances up to four to five inches.[4] Early in my surgical training a woman with a heretofore asymptomatic hiatus hernia was operated upon for a volvulus of the cecum. Recurrent abdominal distention required a Levine tube with nasogastric suction off and on for the better part of nine days. The hiatus hernia became symptomatic, a reflux esophagitis developed, and six months later surgery was required to correct the hiatus hernia.

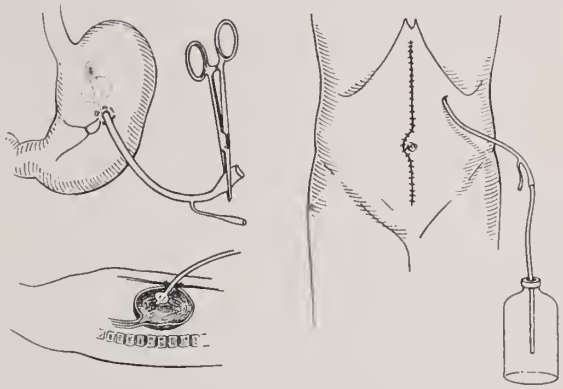


FIGURE 1. Technique of temporary tube gastrostomy.

In their initial report on temporary tube gastrostomy, in an effort to compile further data on the three common complications of nasogastric suction, namely laryngeal obstruction, ulceration and late stricture of the esophagus, Farris and Smith[3] sent questionnaires to 200 specialists in laryngology and bronchoesophagology. The 115 responses revealed a total of 260 major laryngeal and esophageal complications, resulting in seven deaths. Seventy-nine of the 238 laryngeal complications required tracheostomy.

Indications, Technique and Results

Since 1958 I have used temporary tube gastrostomy in 99 patients. The technique is illustrated by Figure 1. After placing a 2-0 silk

†*Presented at the Fourteenth Annual Meeting of the Kentucky Surgical Society at Lexington on May 18, 1963.*

purse string suture in an avascular area of the midportion of the anterior surface of the stomach, midway between the greater curvature and lesser curvature, a #26 Foley catheter with a 30 cc. balloon is inserted into the stomach through a small stab wound in the area surrounded by the purse string. The balloon is immediately inflated with 10 to 15 cc. of sterile saline, and the purse string is tied, inverting the stomach wall about the tube. A second purse string is then placed about the catheter and tied. A stab wound is then made in the left upper abdominal quadrant three inches or so lateral to the mid-line, and the end of the catheter is pulled out through this opening. Several 2-0 silk sutures are then placed about the tube between the peritoneum and stomach wall, approximating the anterior stomach wall snugly to the peritoneum. Throughout the procedure a clamp is kept on the open end of the catheter in order to prevent any spillage of gastric content. With traction on the tube, a skin suture is placed and looped about the tube several times before tying it. After the dressing has been applied, the tube is taped and pinned to abdominal dressing. The tube is then connected to a bedside bottle for gravity drainage. Neither suction nor an underwater seal is employed. Irrigation of the tube has not been required. Beginning on the first postoperative day, an ounce of water is given orally to the patient every three hours while awake. The gastrostomy tube is not pulled through the omentum as has been described by others.[1, 2]

The gastrostomy tube is removed on or after the 7th postoperative day with the stomach empty. A tight dressing is applied over the site and the patient is kept flat in bed for an hour or two before being allowed up and to eat. When the dressing is removed the following morning, the gastrostomy site is found to have sealed over, and over this a small dressing is applied. In two elderly patients who became confused and had a protracted postoperative course following surgery for abdominal aortic aneurysms, the gastrostomy tube was utilized for supplemental feedings.

This procedure has been used in a variety of abdominal operations, i.e., surgery of the abdominal aorta, iliac arteries or renal arteries, esophageal hiatus hernia repair, vagotomy with pyloroplasty or antrectomy, simple closure of perforated peptic ulcers, wedge resections of gastric ulcers in association with other abdominal operations, extensive biliary tract surgery associated with duodenotomy, for intestinal obstruction due to regional ileitis hemicolectomy, and adrenalectomy. Temporary tube gastrostomy has not been used with subtotal gastric resection, because, following a 65 to 75 per cent resection, the gastric remnant is usually not mobile enough to pull it up against the anterior peritoneum without tension, and customarily nasogastric suction is employed for only 12-18 hours following subtotal gastrectomy.

Complications

Three complications that could be attributed to the temporary tube gastrostomy have occured in the 99 patients in whom the procedure was performed, two of the complications occurring in the same patient following two different operations.

A brief description of the complications follows:

CASE 1. A 75-year-old diabetic female who had incomplete thrombotic occlusive disease of the abdominal aorta and iliac arteries was operated upon on 9-12-58 for extrahepatic obstructive jaundice due to a benign papillary adenoma of the ampulla of Vater. She had not vomited prior to surgery. A choledochostomy, duodenotomy, cholecystojejunostomy, and a temporary tube gastrostomy were done. The gastrostomy tube was removed on the eleventh postoperative day but had to be reinserted 24 hours later because of profuse drainage through the gastrocutaneous fistula. The second tube was removed 72 hours later and small amounts of drainage occurred for an additional three days.

This patient should have had a gastrojejunotomy at the time of the initial surgery because the duodenotomy and the ampullary tumor undoubtedly produced a partial duodenal obstruction, resulting in failure of the gastrostomy site to close promptly.

She was readmitted to the hospital in late January 1959, some four months later, with vomiting of three weeks' duration and obstruction of the second portion of the duodenum. An antecolic gastrojejunostomy and temporary tube gastrostomy were carried out on 2-2-59. The gastrostomy tube was removed on the 9th postoperative day and troublesome drainage through the gastrocutaneous fistula occurred for seven days, resulting in some excoriation of the adjacent skin. No fluid or electrolyte prob-

lem ensued, and no intravenous fluids were required.

CASE 2. A 42-year-old man was operated upon on 8-20-60 for what was thought to be an acute intestinal obstruction with strangulation. An acute segmental ileitis of the proximal ileum was found. It was felt that this would probably subside spontaneously and accordingly a temporary tube gastrostomy was done. Eight hours later hematemesis occurred as well as bloody drainage through the tube. Several transfusions were given. Two days later he was reoperated and the stomach detached from the anterior abdominal wall. A vertical incision was made adjacent to the gastrostomy and a small clot was noted adherent to the gastric mucosa a few millimeters away from where the gastrostomy tube was inserted. The entire gastrostomy site was excised and the incision was then extended to explore the entire stomach but no other source of bleeding was found. A new gastrostomy tube was inserted which was removed ten days later.

Microscopic sections showed a small segment of stomach with some hemorrhagic tissue adjacent to the gastrostomy. There were several small arteries in the adjacent submucosa but no direct connection was demonstrable between the vessels or adjacent clot.

Probably when the purse string suture was inserted, the needle inadvertently pierced the mucosa and was withdrawn, accounting for the bleeding.

Complications of temporary tube gastrostomy are related to leakage resulting in peritonitis or intraabdominal abscess, persistent gastrocutaneous fistula following removal of the tube, and bleeding.[3, 4, 5, 6, 7]

Gillesby and Puestow[4] reported a fatality in an elderly man who, following a gastric resection, removed the tube in his sleep. The parietal and visceral peritoneum had not been approximated, and despite reoperation the patient died of peritonitis.

Senter[6] reviewed fifty patients in whom tube gastrostomy was utilized and three of these patients died as a direct or indirect result of the procedure. One death occurred following loss of gastric fluid over a twenty-eight-day period due to failure of the gastrocutaneous defect to close after removal of the tube. The patient had been on steroid therapy for four and a half years. The second death occurred in a patient who had the tube removed on the fifth postoperative day and who had a dehiscence of the abdominal wound the next day following a violent coughing spell. At reoperation the stomach was unknowingly sheared away from the anterior abdominal wall, and the gastrostomy site reopened, the patent dying nine hours later of shock and peritonitis. A third fatality occurred as the result of a gastrocutaneous fistula complicating a left subdiaphragmatic abscess.

Smith and Farris[7] in 1961 in re-evaluating temporary gastrostomy as a substitute for nasogastric suction collected data on 2,512 patients in whom the procedure was employed. In this series there were three and possibly four major complications which were related to the gastrostomy.

Meticulous attention to technique and detail should all but eliminate complications associated with this procedure. As Senter has emphasized previously,[6] the tube should be placed into an avascular area in the mid-portion of the stomach, the edges of the stomach about the gastrostomy should be inverted, the stomach should be carefully approximated to the peritoneal wall, and slight traction should be kept on the catheter as it emerges from the abdominal wall. Early removal of the tube before the seventh postoprative day should be avoided and the tube should be removed with the stomach empty.

Summary

Temporary tube gastrostomy is an effective method to keep the stomach and intestine decompressed when prolonged postoperative ileus is anticipated.

The disadvantages of prolonged nasogastric suction and the advantages of temporary tube gastrostomy are discussed. The major complications of the procedure are leakage about the tube, persistent gastrocutaneous fistula following removal of the tube, and bleeding from the gastrostomy site. Meticulous attention to detail and technique should minimize or eliminate these complications.

The technique as employed by the author is described and was used in ninety-nine patients with three complications. A patient with bleeding from the gastrostomy site was successfully reoperated. There were two instances of prolonged drainage from the gastrostomy site following removal of the tube one for three

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The Treatment of Arteriosclerotic Gangrene of the Foot by Arterial Reconstruction and Local Amputation

FRANK C. SPENCER, M.D.* AND PAUL R. WINSLOW, M.D.**

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Reconstructive arterial surgery may prevent amputation in some elderly patients with gangrene of the foot from occlusive arterial disease. Four patients with good results lasting one to three years after operation are reported.

Introduction

ADVANCES in reconstructive operations for occlusive arterial disease of the lower extremities have made it possible to salvage many gangrenous extremities which formerly could be treated only with a low-thigh amputation. The four patients described in this report demonstrate not only that reconstructive arterial surgery may be successful despite advanced age, diabetes, and localized gangrene of the foot, but also that initial good results may be maintained for long periods of time.

Case Reports

Case 1. R. H., a 47-year-old farmer, was admitted to the Johns Hopkins Hospital in November, 1960, for extensive gangrene of the anterior portion of the left foot. Eighteen months earlier moderate intermittent claudication developed and was soon followed by a persistent local infection in the left third toe. Mild diabetes mellitus was discovered at this time which was easily managed with Orinase®. Three weeks before admission the third toe suddenly became gangrenous and was amputated. While convalescing in the hospital, gangrene gradually developed in the second and fourth toes and spread proximally onto the foot. (Fig. 1)



FIGURE 1. Case 1. Extensive gangrene involves the distal half of the foot. Following a successful femoral-popliteal bypass graft, the gangrenous area was excised and a skin graft applied.*

Examination showed a left femoral pulse at the inguinal ligament, but none distally. Aortography found stenosis of the common femoral artery, occlusion of the superficial femoral artery, and irregular narrowing of the popliteal artery. On November 2, 1960, the stenosis of the common femoral artery was corrected with an endarterectomy, after which an 8 mm. knitted Dacron graft was inserted with end-to-side anastomoses from the common femoral artery proximally to the bifurcation of the popliteal artery below the knee. The foot immediately became warmer though no pedal pulses were palpable. On November 12, 1960, the gangren-

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ous area of the foot was removed as a wedge excision, following which a skin graft was applied several days later. In January, 1964, thirty-eight months after operation, he was in good health with an asymptomatic foot.

Comment. The development of gangrene in the second and fourth toes following its initial appearance in the third toe is a typical sequence of events in a severely ischemic foot, where relatively minor trauma will initiate a spreading gangrene often resulting in a low-thigh amputation. The presence of diabetes did not adversely influence the surgical result.

Case 2. C.D., a 65-year-old male, was hospitalized at the Johns Hopkins Hospital, Baltimore, Maryland, in October, 1960, for gangrene of the first and fifth toes of the right foot beginning three weeks earlier. This started after removal of the toe nail from the great toe because of a persistent local infection. He had had diabetes for the two previous years, requiring 15 units of insulin daily. Intermittent claudication of moderate severity had been present for two years.

Examination showed a strong arterial pulse in the right thigh at the inguinal ligament, but no pulse could be felt distally. Both the first and fifth toes were gangrenous, and the second toe was cyanotic. An arteriogram showed stenosis of the common femoral artery near its bifurcation, occlusion of the superficial femoral artery, and a patent popliteal artery. On October 27, 1960, an endarterectomy was performed on the common femoral to increase blood flow to the profunda femoral artery, after which an 8 mm. knitted Dacron graft was inserted with end-to-side anastomoses from the common femoral proximally to the bifurcation of the popliteal artery below the knee.

Following operation the foot became much warmer, and a pulse could be felt posterior to the lateral malleolus, which probably originated from the peroneal artery. Eight weeks later the first, second, and fifth toes were separately amputated, following which the incisions healed promptly. For the next year he had no further difficulty with his foot. At that time he died suddenly from a myocardial infarction.

Case 3. D.C., a 66-year-old colored male, was hospitalized in January, 1962, at the Veterans Administration Hospital, Lexington, Kentucky, for progressive arterial gangrene of the left leg. For the preceding year claudication had limited walking to 90-100 feet. Six months before admission minor trauma over the left leg resulted in an ulcer which gradually enlarged to a diameter of 3 cm. Three months before admission an 8 X 10 cm. area of gangrene developed over the dorsum of the left foot (Figure 2). This resulted in rest pain only partly relieved by keeping the foot dependent.



FIGURE 2A

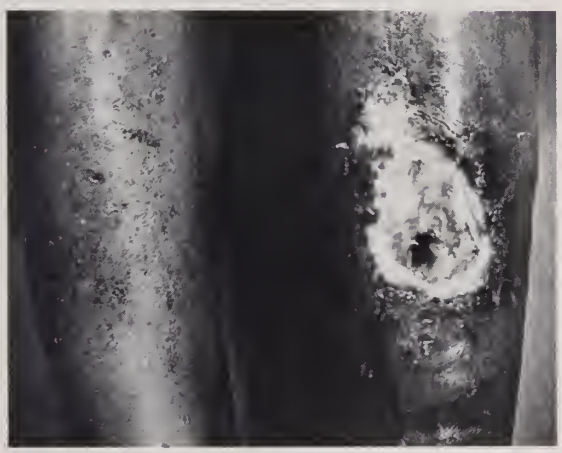


FIGURE 2B

FIGURE 2. Case 3. (A) Extensive gangrene involves the first and second toes of the foot and extends over the dorsum of the foot. (B) Ischemic ulcer present for 6 months following minor trauma over the mid-portion of the leg.

Physical examination showed a severely ischemic left leg with a weak femoral arterial pulse and absent distal pulses. Arterial pulses in the right leg were normal. A left femoral



FIGURE 3A FIGURE 3B

FIGURE 3. Case 3. (A) Appearance of foot after successful femoral-popliteal bypass graft. The gangrenous toes were excised and the gangrenous area over the dorsum of the foot debrided, after which a skin graft was applied. (B) The ischemic ulcer was successfully closed with a skin graft following insertion of the femoral-popliteal bypass graft.

arteriogram showed occlusion of the left superficial artery with patency of the popliteal artery at the knee.

On February 16, 1962, operation was performed. Atherosclerotic narrowing of the common femoral artery was corrected with an endarterectomy from the distal external iliac artery to the origin of the profunda femoral artery. An 8 mm. knitted Dacron bypass graft was then inserted with end-to-side anastomoses from the external iliac artery proximally to the bifurcation of the popliteal artery below the knee. A dorsalis pedis pulse became palpable after operation with an immediate increase in warmth of the foot.

One month later, when the areas of gangrene were clearly demarcated, they were surgically excised and skin grafts applied. The first and second toes were amputated. All wounds healed promptly, following which the patient was discharged in good condition. (Figure 3).

Twenty-one months later, December, 1963, he was asymptomatic and walking without any limitations. Strong pulsations were palpable in the Dacron graft, and a good dorsalis pedis pulse was present.

Case 4. A.T., a 65-year-old male, was hospitalized at the Lexington Veterans Administration Hospital, Lexington, Kentucky for severe claudication and rest pain in the right foot in April, 1962. Intermittent claudication had begun ten years before and gradually increased in severity. Three years before admission a gangrenous left fifth toe was removed and a lumbar sympathectomy performed. A year later an aortic endarterectomy and a left femoral bypass graft was complicated by a wound infection and thrombosis of the graft, resulting in a mid-thigh amputation.

On physical examination the left femoral pulse was absent and the right one barely palpable. No distal pulses could be felt. The right foot showed the atrophic changes of severe ischemia—rubor, atrophy, and coldness. Aortography showed occlusion of the left iliac artery and stenosis of the right. Femoral arteriography showed occlusion of the superficial femoral artery and narrowing of the popliteal artery.

On April 22, 1962 a 10 mm. Dacron bypass graft was inserted from the aorta to the external iliac artery. An endarterectomy was then performed upon the distal external iliac and the common femoral artery, after which an 8 mm. Dacron bypass graft was inserted with end-to-side anastomoses between the common femoral artery and the popliteal artery just proximal to the knee joint. Two individual grafts separated by a short segment of endarterectomized artery were thought preferable in the flexion crease to a single long graft which might buckle and thrombose when the lower extremity was flexed.

Following operation all ischemic symptoms subsided, and a dorsalis pedis pulse could be felt in the foot. This pulse remained palpable for a year after operation, after which it could no longer be left. Eighteen months after operation (December, 1963) a strong femoral pulse remained palpable, though no distal pulses could be felt. There were moderate signs of ischemia in the foot.

Discussion

The most significant point with these four patients is that arterial reconstruction not only prevented immediate amputation of the gangrenous extremity, but continued to function satisfactorily for 12, 21, 23, and 38 months respectively. These good results were obtained despite the fact that two of the patients were diabetic, some were elderly and all had atherosclerosis extending from the external iliac or common femoral artery to the distal popliteal artery.

Surgical Technique. Several technical points influenced the good results. Stenosis of the common femoral artery contributed to the severity of the ischemia in all four patients. This was corrected with an endarterectomy of the common femoral artery before the bypass graft was inserted. A large (8 mm.) knitted Dacron graft was used; this diameter insures adequate blood flow, and the porosity of the knitted graft facilitates the ingrowth of fibrous tissue. Distally the prosthesis was extended across the knee joint to the distal popliteal artery in three patients in order to insure a good "run-off" for blood flowing through the graft. When possible, prosthetic grafts are not placed across the knee-joint because late stiffening of the graft from ingrowth of fibrous tissue may result in kinking and thrombosis when the joint is flexed. Such a graft must be used, however, if the proximal popliteal artery is badly diseased.[4] In the future an autogenous vein graft may prove to be a better choice in such patients if a vein of sufficient length is available, and reports of initial good results are sustained.[2]

When atherosclerosis extends from the iliac to the popliteal artery, the preferred operation is either an iliac endarterectomy[1] combined with a femoral bypass graft, or the insertion of individual iliac and femoral bypass grafts separated by a short segment of endarterectomized femoral artery (Case 4). Long single prostheses extending from the aorta to the popliteal artery, with a side-to-side anastomosis between the graft and the common femoral artery, have had a high rate of thrombosis within the first year after operation.

Operative Arteriography. Extensive atherosclerosis producing gangrene of an extremity can be surgically corrected only when at least one tributary of the popliteal artery is patent. However, if all three of the popliteal tributaries (the anterior tibial, posterior tibial, and peroneal) are severely diseased, vascular reconstruction is impossible, and amputation must be performed. The crucial decision—attempted vascular reconstruction or amputation—can be made only from arteriograms clearly defining the tributaries of the popliteal artery. If these can not be obtained by percutaneous injection, the popliteal artery should be exposed and operative arteriograms performed. As long as gangrene is limited to the distal half of the foot, *no* amputation should be done until arteriography has shown that all three tributaries of the popliteal artery are hopelessly occluded.[3]

Summary

Four patients, two of whom were diabetic, with severe ischemia of the foot from extensive atherosclerosis have been successfully treated by a combination of endarterectomy, bypass grafts, and local amputation. Gangrene of the foot was present in three of the patients, while the fourth had severe rest pain. The initial good results continued for 12, 21, 23, and 38 months, respectively. These experiences emphasize that *no* amputation should be performed for gangrene limited to the distal half of the foot until arteriography has demonstrated that all three tributaries of the popliteal artery are hopelessly occluded.

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Recent Advances in Glaucoma

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This article is designed to bring the non-ophthalmologist up to date on the recent advances in glaucoma work. The disease, its diagnosis and treatment are discussed.

WHAT is going on? To answer this question in one's own field of interest is no problem. It is becoming increasingly difficult to keep up in specialities not directly related to one's field. The following article is designed for the man who has not been in medical school for several years and who would like to know the developments in the field of glaucoma.

Glaucoma is an increased pressure in the eye which leads to loss of visual fields with atrophy and cupping of the optic nerve. There are many kinds of glaucoma, but broadly speaking, there are two major types. The first is much less common. It is closed angle glaucoma. In closed angle glaucoma the iris becomes adherent to the outflow channels leading to Schlemm's canal, causing an abrupt rise in intra-ocular pressure. The patient usually comes in immediately complaining of severe pain in the fifth nerve distribution, blurred vision, and halos. The eye is red with a semi-dilated fixed pupil. The cornea is hazy, the intra-ocular tension is high, and there is sometimes nausea and vomiting.

Treatment

The treatment of closed angle glaucoma is peripheral iridectomy. This allows the aqueous access to the outflow channels. It is important that the pressure in these acutely inflamed eyes be brought down immediately and before iridectomy is performed. If this isn't done within one to five days the iris becomes permanently adherent to the sclera in the area of the outflow mechanism. When this happens the aqueous can not get into Schlemm's canal and peripheral iridectomy is ineffective. In some of these cases the pressure can not be brought down with routine methods. In the last few years osmotic agents such as urea and mannitol have been used. These almost always dramatically lower the pressure. Once the pressure is down, the usual drugs will keep it down till surgery can be done.

The second type is open angle glaucoma. Here there is gradually increasing resistance to the escape of the aqueous in the outflow channels. The pressure is not so high as in closed angle glaucoma. There are usually no symptoms with this disease till late. Occasionally the patient will complain of headaches or of halos about lights.

Among therapeutic agents nothing developed has been as dramatic as the osmotic agents. There has been a significant increase in the therapeutic armamentarium. It has been shown by tonography that topical epinephrine suppresses the rate of aqueous secretion 37%. Acetazolamide (Diamox®) suppresses the rate 50%. Those effects are additive. Average combined suppression is 66%.[1] This lowers the intra-ocular pressure. Also, use of epinephrine over long periods of time has been shown to increase the outflow of aqueous[2]. An interesting group of drugs that is being used more and more are the long acting anticholinesterase drugs. These drugs increase the facility of outflow and are frequently used only once daily. Severe systemic anticholinesterase effects are rare, but exploratory laparotomy has been done because of these effects, while keeping the patient faithfully on his anti-glaucoma drops. The systemic side effects are nausea, diarrhea, bradycardia, salivation and sweating. Phospholine Iodine, Floropryl®, and Humersol® are commonly used drops in this group. These drugs are not usually resorted to unless other measures fail. Increasing the armamentarium is important so that when one drug fails we can fall back on another rather than resort to surgery.

One of the recent advances in glaucoma concerns delineating the course of open angle glaucoma, especially the early phases[3]. First there is an inability for the aqueous to escape from the eye after the patient drinks large amounts of water. This may be intermittant be-

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fore becoming persistent. Later this impaired outflow of the aqueous occurs without drinking the water. This also may be intermittant, even late in the disease. Later the intra-ocular pressure becomes elevated. After a time, which may be years, the patient begins to lose field and to develop optic atrophy and cupping of the nerve head. During periods of pressure elevation the physiologic blind spot gradually enlarges. Scotomata also occur in the peripheral field. Patients usually don't notice these until they overlap one of the blind areas in the opposite eye. Even during the last stages the intra-ocular pressure may revert to normal for a time, only to become elevated later. Family studies of glaucoma patients have shown that the disease may advance to any one of these steps and stop with no further advancement. Also, the patient can go to complete blindness without pain or any other noticeable symptom.

Diagnosis

Another important development in diagnosis is the increasing awareness among physicians of another rare type of glaucoma. Infantile glaucoma is a disease with a poor prognosis unless diagnosed early. Symptoms may occur at birth but usually occur later during the first three months of life. Suspicion is aroused when the baby has photophobia, tearing, blepharospasm, and corneas which later enlarge. Some surgeons have reported curing as many as 90% of these infants with surgery[4].

The most important recent trend in glaucoma lies in diagnosis. For many years, most ophthalmologists felt that the taking of the intra-ocular pressure (tonometry) was their special province.[5] This resulted in many patients never having their intra-ocular pressure measured. Many people escape examination by an ophthalmologist for their entire life. Yet two and one half percent of the population over forty have open angle glaucoma. Most of these are undiagnosed. Most ophthalmologists now feel that tonometry should be part of every routine physical examination. The equipment is not expensive. When anesthetic agents, such as Ophthaine® or Dorsacaine® are used the procedure is fast and painless. Many physicians have made this simple test a part of every routine physical examination.

If the tension is 21 or above the patient will need further diagnostic tests. It has been found that only one normal person in forty has a pressure of 21 or above but one half of the patients with this pressure will have glaucoma.[3]

Another important step forward in the diagnosis of glaucoma is the use of tonography. Although the principles of tonography have been known for years[6], it only recently has become widely used and accepted by ophthalmologists. If an eye is massaged forcefully the aqueous will be squeezed out and the eye will become soft. In a glaucomatous eye the aqueous leaves the eye less readily. Tonography quantitates this massage effect. In actual practice tonography is usually done by placing an electronic tonometer on the eye for four minutes and measuring the decrease in pressure caused by the weight of the tonometer. There is less decrease in pressure in the glaucomatous eye. This is more noticeable if the patient has consumed a quart of water 45 minutes prior to the tonography.

A study using patients with proven glaucoma illustrates the effectiveness of tonography. All these patients (300 eyes) were taken off their antiglaucoma therapy. By tonography alone, 66% could be detected. Using water drinking tonography 94% could be detected. For contrast, only 29% of glaucoma patients are detected by the water provocative test alone when an 8 mm. rise in intra-ocular pressure is used as the criteria for the positive test.[7] Using 6 mm. as a criteria 47% are positive but 2% of normal eyes will react this way.

Another important aid in the diagnosis and treatment of glaucoma is the growing acceptance and use of the applanation tonometer. This is a special tonometer which avoids some of the disadvantages of the Schiotz tonometer. The Schiotz tonometer is the most widely used. It has a small plunger with a known weight which is placed on the cornea. The more the cornea indents, the lower the pressure in the eye. In some eyes the rigidity of the sclera and cornea is less than others. If the rigidity is lower than usual, the pressure will be recorded lower than it really is. This can be detected by using two weights. If the pressure measures lower with the higher weight the tension is higher than either. A difference of two is considered significant. On the other hand, the applanation tonometer works by flattening the cornea rather than indenting it. A large clear plunger is used and the amount of pressure required to flatten the cornea to a predetermined amount is found. The amount of pressure required is a measure

of the intra-ocular tension. Very little aqueous is displaced so that a true reading is obtained in the occasional eye which has abnormal scleral rigidity. However, this tonometer is expensive and requires the use of the slit lamp. It is too time consuming to be used as a screening device.

Another interesting development is the discovery that long time use of topical steroids in the eye causes a reversible glaucoma.[8] Systemic steroids have also been implicated.[9, 10] This is interesting because it gives us a means of producing experimental glaucoma. We must regularly check the intra-ocular pressure of the patients on long term topical or systemic steroids. Patients should not be given prescriptions of topical ophthalmic steroids for minor conditions nor should they be allowed to refill these prescriptions as they desire.

Fortunately, the most significant developments in glaucoma have occured in early case findings. It is most satisfying to diagnose these cases early for it is then that we can help our patients most.

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Leukemoid Response to Overwhelming Infection In a Patient with Pernicious Anemia in Relapse: A Case Report

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A case is reported with pernicious anemia, leukemoid response, and overwhelming infection due to Mimae polymorpha. The leukocytes were right shifted neutrophils and their increase was felt to be due to a release phenomenon.

PATIENTS with pernicious anemia in relapse are commonly described as showing an absolute neutropenia (3,000-5,000 leukocytes per c.mm.) and a relative lymphocytosis.[1] Although an occasional patient may exhibit myeloid immaturity, the most characteristic finding in the leukocytes is the presence of large multi-segmented polymorphonuclear leukocytes. In the bone marrow, neutrophilic precursors may be observed as giant metamyelocytes. The nuclei of the smaller, more mature myelocytes, exhibit multiple sites of pinching, which result in the development of the hypersegmented polymorphonuclear leukocyte.[2] It is felt that these changes are the result of the same defect in cellular metabolism that produces the megaloblast and macrocytosis. The megaloblast and the giant metamyelocyte are believed to result from a prolonged phase between mitosis with retardation of maturation.[3]

It is the purpose of this paper to present a patient with pernicious anemia *in relapse* who exhibited a leukemoid response to a severe overwhelming infection.

Case Report

This fifty-seven year old white male was admitted to the University of Kentucky Hospital on April 27, 1963. He had been transferred from another hospital for the evaluation of a systemic illness. On admission, the patient was confused and acutely ill, and an accurate history was difficult to obtain. The patient had evidently been well until November of 1962 at which time he had had the onset of chest pain which involved the right and left anterior chest and was associated with cough. The cough was productive of thick, yellow sputum. These symptoms continued and became associated with a severe headache and progressive muscular weakness. A chest x-ray on April 15, 1963 had shown an infiltration of the right upper lobe. He also gave on admission, a history of vertigo and joint pains of two years' duration. He noted that in the past two months, his vertigo had become constant. His white blood count on admission to that hospital had been 12,300, hemoglobin 12.6 gm. per cent, and hematocrit 37%. The patient was treated with INH 400 mg., PAS 10 gm., Prednisolone 30 mg., Sulfadiazine 4 gm., Potassium Iodide 100 drops per day. Two days later he was started on Fungizone, of which drug he received 345 mg. and Mycostatin, 4 million units. Because of a failure to respond and progressive deterioration in his condition, he was transferred to this hospital.

His admission physical revealed a severely ill white male who was dyspneic and dehydrated. The vital signs were as follows: temperature 98.4, blood pressure 115/70, pulse 120, and respiratory rate 34. The positive pertinent physical findings were a smooth tongue, dullness at the right lung base which was felt to be compatible with fluid, tubular breath sounds and sticky rales in the right lower and middle lobes and the left lower lobe.

Neurological examination showed hypoactivity of the tendon reflexes with absence of the cremasteric and abdominal reflexes. Vibratory sensation was absent in the upper and lower extremities. Proprioception was absent

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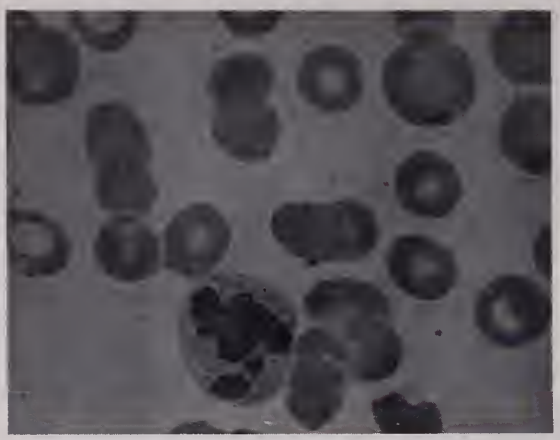


FIGURE 1. Large hypersegmented polymorphonuclear leukocyte.

in the lower extremities. Light touch, pain and dull pressure were felt to be decreased in the lower extremities. A left foot drop was present. There was considerable muscle wasting both proximally and distally, with muscle tenderness.

An admission chest film revealed extensive fibrotic changes over both lung fields. There was enlargement of the right hilus. Pleural thickening and fluid were present bi-laterally.

His admission blood count revealed a hemoglobin of 11.6 gms. per cent, hematocrit 36%, leukocyte count 33,500, segmented neutrophils 97%, lymphocytes 2%, and monocytes 1%. Examination of the blood smear revealed an oval macrocytosis, anisocytosis, and poikilocytosis. The neutrophils were noted to be large with more than the usual number of segments. No myeloid immaturity was noted. These changes are illustrated in Figure 1. Examination of the pleural fluid revealed mesothelial cells with large nuclei. The rest of the laboratory studies including liver function tests and electrolytes were within normal limits.



FIGURE 2. Section of lung showing extensive obliterative bronchiolitis.

The patient expired on the second hospital day. At post-mortem examination the main findings were as follows: The lungs showed an organizing pneumonia with obliterative bronchiolitis as shown in Figure 2. The stomach showed atrophy of the gastric mucosa and one gastric polyp. The spinal cord showed posterior lateral sclerosis as shown in Figure 3. The latter two findings were compatible with those seen in pernicious anemia. Culture of the lungs and of small vegetation on the aortic valve grew out *Mimae polymorpha.*

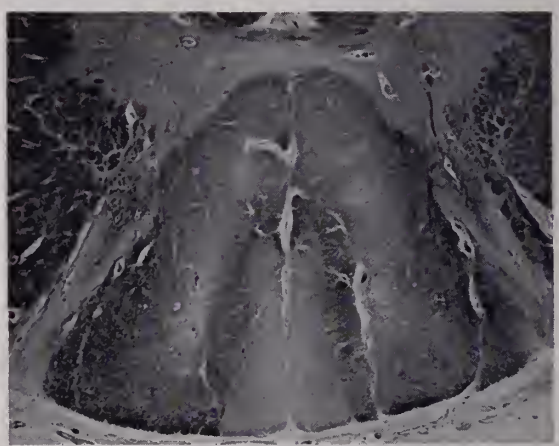


FIGURE 3. Section of the spinal cord showing posterior lateral sclerosis.

Discussion

The leukemoid response has been described in association with a variety of infections, intoxications and malignant disorders. It is felt that this patient's leukocytosis was in response to an overwhelming pneumonia. Usually the leukemoid response to infection is characterized by a shift to the left with large numbers of immature myeloid elements appearing in the blood. This is felt to be due to acceleration of myelopoiesis and accelerated release of granulocytic elements from the marrow into the blood.

It is felt that this patient's leukemoid response could only be due to accelerated release of hypersegmented polymorphonuclear leukocytes from the marrow since the patient would be incapable of accelerating the rate of myelopoiesis because of B_{12} deficiency. This concept is given further support by the fact that no immature granulocytic elements were found in the blood and the leukocytes were "right shifted."

The normal number of lobes in the poly-

morphonuclear leukocyte is three, and about 50% will have this number. About 25% will have two lobes and about 25% will have four lobes. In this patient, the polymorphonuclear cells were markedly hypersegmented: 1% had three lobes, 31% had four lobes, 27% had five lobes, 27% had six lobes, 11% had seven lobes, and 3% had eight lobes.

Several patients with pernicious anemia have been described with a leukemoid response associated with infection.[4, 5, 6, 7] A review of these patients shows that all of them had marked myeloid immaturity commensurate with the elevation in leukocytes.

We can only speculate that the severity of the B_{12} deficiency in our patient was too great to allow this type of myeloid response. The only response possible in this patient was the release of stored mature neutrophils.

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Remember to Plan

to attend the

KMA Interim Meeting March 18

and

You are invited to the

"Open" Meeting of the House of Delegates

Wednesday, March 17, 8:00 p.m.

Gabe's Restaurant

Hear Edward R. Annis, M.D., and Congressman Durward G. Hall, M.D.

Perforated Gastric Ulcer With Accessory Pocket Formation Simulating Diverticulum of the Stomach

James A. Baumgarten, M.D.
Owensboro, Ky.

Perforation of a gastric ulcer with accessory pocket formation is discussed and a case showing a large pseudodiverticulum of the stomach is presented.

A CHRONIC perforated peptic ulcer with an accessory pocket or pseudodiverticulum is one of the most common of the non-sealed walled-off perforations. The walled-off pocket of this type of perforation does not ordinarily form a localized gas pocket, since it has a large hiatus. The communication between the viscus and the pocket is clearly demonstrable in the majority of cases. There may or may not be symptoms of the condition at the time of the examination.

Presentation of Case

This 53-year-old white female was first seen in the physician's office because of the chief complaint of cramping pains in both lower extremities, aggravated by standing and walking. The pains were described as being dull and aching in nature and had been intermittently present over a twenty year period with a recent increase in intensity over the past two months. Physical examination at that time revealed a well developed, slightly thin white female in no acute distress. Her blood pressure was 136/78 and her pulse regular at 90. Examination of the lower extremities failed to reveal any significant abnormalities. The dorsalis pedis pulsations were readily palpable bilaterally, and there was no evidence of varicosities. Complete pelvic examination was within normal limits. However, examination of the abdomen revealed a palpable mass in the mid epigastrum described by the examiner as being "lemon sized" and cystic in nature. The mass was freely movable and was not tender. No other abnormalities were present in the physical examination.

The patient's past history was essentially noncontributory. The system review history was negative except that the patient had noted a slight weakness following heavy household chores in the past year. There was no history of gastro-intestinal symptomatology. The patient had an umbilical and left inguinal herniorrhaphy in 1957 with no sequelae.

The patient was then admitted to the medical service of St. Joseph Infirmary, Louisville. Physical examination on admission revealed a well developed, well nourished, white female. Blood pressure 130/80, pulse 90, respiration 20/minute, temperature 99.6 degree. Examination of the abdomen confirmed the presence of the previously described cystic mass in the mid epigastrum; no tenderness or rebound was present, and no other abdominal masses or significant abnormalities were found.

Laboratory Data

On admission the RBC count was 3,500,000, Hgb 11 gms., C.I. 1.04, WBC 16,200, differential: 81 segs, 5 non segs, 2 monocytes, 12 lymphocytes. The sedimentation rate was 31 mm/hr (normal 0-10). Serum amylase, serum lipase, alkaline phosphatase, total protein and A/G ratio, cephalin floculation, total and direct bilirubin, SGOT, PBI, Blood sugar, blood cholesterol, NPN, calcium, phosphorus, urea nitrogen, and BSP examinations were normal. Febrile agglutinations were negative. A gastric analysis revealed the presence of free HC1 in the fasting state with a significant rise following alcohol and histamine administration. Cell block studies of gastric contents failed to reveal any malignant cells. A bone marrow examination was normal.

Radiological Examinations

Roentgenograms of the chest, lumbar spine, and lower extremities were interpreted as nor-

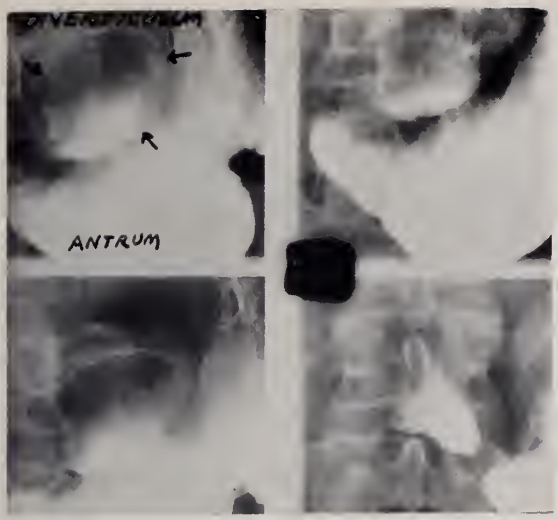


FIGURE 1. Upright spot films showing the pouch-like defect arising from the lesser curvature of the stomach. Note the air-fluid level in the pseudodiverticulum.

mal. Cholecystograms on the day after admission revealed no dye in the gall bladder. A repeat examination the following day using a double dose of dye revealed a satisfactory concentration of dye with no abnormalities present. A barium enema examination was within normal limits.

An upper GI examination done two days after admission showed the stomach to be of normal size and position with normal mobility and motility. The barium was observed to flow immediately into a cystic pouch-like defect arising from the middle third of the body of the stomach along the lesser curvature, and an air-fluid level was observed in the defect at fluoroscopy. The defect was approximately 8 cm. in its greatest diameter and seemed freely movable with no tenderness present. Peristalsis was active throughout the entire stomach. With the patient in the left and oblique upright position, the defect appeared to be on the anterior wall of the stomach with the barium filled pouch projecting anteriorly. The pylorus and duodenum filled immediately. The duodenal bulb and duodenal loop were normal. At two hours there was satisfactory gastric emptying and only a small amount of barium was retained in the defect. Roentgen interpretation was either a large gastric diverticulum projecting from the lesser curvature or a duplication anomaly of the stomach.



FIGURE 2. P.-A. roentgenogram showing the pouch-like defect on the lesser curvature of the stomach.

A repeat examination done two days later revealed essentially the same findings as seen on the intial examination.

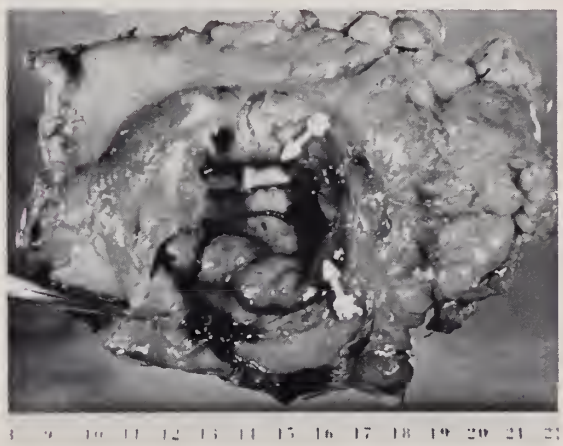


FIGURE 3. Gross specimen of the stomach. The arrows point to the margins of the ulcer crater on the lesser curvature.

Operative Findings

An exploratory laporotomy was performed seven days after admission. A midline upper abdominal incision was made extending from the xyphoid process to the umbilicus. The small and large intestine, spleen, kidneys, and pancreas showed no abnormalities. The stomach showed intensive inflammatory reaction along the lesser curvature where an abscess cavity extended into the liver substance. There were numerous adhesions of the omentum and the stomach to the left lobe of the liver and to the abscess cavity. The stomach was dissected from the liver and in the process the abscess cavity was opened, revealing a perforation along the lesser curvature of the stomach, measuring approximately 2½ cms. in diameter, which extended into the cavity. The cavity was firmly

adherent to the undersurface of the left lobe of the liver. A gastric resection was done and a liver biopsy was taken at the site of the abscess. A second liver biopsy was taken in a normal area of the liver.

Pathological Report

"The specimen consists of a portion of stomach which measures approximately 170 mm. as measured along the greater curvature. There is a large ulceration near the lesser curvature which measures about 7 mm. in its greatest diameter. The wall about the ulcerated area measures up to about 15 mm. in thickness. The ulcerated area has extended through the wall of the stomach and was adherent to the liver."

Microscopic Description: "Sections from multiple blocks of the stomach show extensive ulceration. The ulcerated area is covered with necrotic tissue infiltrated with inflammatory cells which contain a number of neutrophils. Deeper the wall of the stomach is infiltrated with inflammatory cells which contain many mononuclear cells, lymphocytes, and eosinophils. There is no histologic evidence of neoplasm. Sections from one block of the liver show all of the liver parenchyma to be obliterated by an inflammatory process with fibrous proliferation. Some of the duct system remains in the liver biopsy. Sections of another biopsy of liver show hepatic parenchyma which is relatively normal in appearance."

Final Diagnosis: "Benign ulceration of the stomach with adhesions to the liver."

Discussion

Perforation is estimated to occur in approximately eight per cent of peptic ulcers. According to Scully, the predominant site of perforation in gastric ulcer is on the anterior wall near the pylorus along the lesser curvature.[3] In Blackford and Baker's review of 21 cases, 18 (85.6%) were on the anterior or superior surface of the duodenum, or on the anterior surface or lesser curvature of the stomach near the pylorus.[2] Perforation may occur at any age, usually between the ages of 20 and 50. This complication is more frequent in the male. In 4590 cases, 4314 were men and 276 were women.[1]

Localized walled-off perforation is not an uncommon complication of peptic ulcer. A chronic perforated peptic ulcer with an accessory pocket or pseudodiverticulum is one of the more common of the non-sealed, walled-off perforations. According to Feldman, they are usually seen in the stomach on the lesser curvature as an extra large pocket of an ulcer crater. He classifies the walled-off type into two varities: (1) the accessory pocket or pseudodiverticulum, adjacent to the ulcer crater, and (2) pockets distant from the site of the ulcer. He further subdivides localized perforations into two types; (1) sealed, and (2) non sealed.[1]

The site of the gas pocket in the chronic walled-off perforation of gastric ulceration varies according to the location of the ulcer. When it occurs on the lesser curvature it is usually adjacent to the ulcer crater and is in close relationship with the body of the pancreas.[1, 5, 6] In this case, however, the pouch was adherent to the liver.

Freedman reported a case of perforated gastric ulcer with an abscess sac situated on the posterior wall of the cardia of the stomach near the greater curvature, simulating a diverticulum of the stomach.[4, 7]

Clinical symptoms of the chronic ulcer with perforation vary. Usually the history is one of persistant epigastric pain, aggravated by food intake, along with vomiting. However, it is noted by several authors that clinical symptoms may be absent in all forms of the sealed or the non sealed walled-off perforations.[1, 5, 6] This case bears out these observations.

Summary

1. A brief discussion of perforated gastric ulcer with accessory pocket formation is presented.

2. Roentgenograms are reproduced from a case with a moderately large cyst-like pouch defect projecting from the lesser curvature of the stomach which simulated a gastric diverticulum, with no related symptomatology.

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Childrens Hospital

Diphtheritic Myocarditis

WALTON M. EDWARDS, M.D.*

DIPHTHERIA was once one of the greatest scourges of childhood and dangerous to all age groups. Through immunization the disease has been steadily decreasing in the United States as shown in Table I.

TABLE I

Incidence of Diphtheria and Mortality

	1963	1962	1961	1960	1959	1958
United States*						
Cases	..	444	636	751	892	924
Deaths	..	..	68	69	72	74
State of Kentucky**						
Cases	2	0	9	56	9	7
Deaths	1	0	1	1	0	0
City of Louisville*** (Jefferson County)						
Cases	2	0	0	0	0	2
Deaths	1	0	0	0	0	0

* United Public Health Service
** Kentucky State Department of Health
*** Jefferson County Board of Health

Although the incidence of the disease is on the decline, the mortality rate remains steady. Diphtheria has not been entirely eliminated. Recently we encountered a tragic and alarming manifestation of the disease in a young male with a fatal outcome.

Report of a Case

An 11-year-old white male was hospitalized at Children's Hospital because of a sore throat and massive enlargement of the neck. (Plate I)

One week prior to admission he had coryza and a nonproductive cough. Five days before admission he complained of a sore throat, and on the following day he awakened with nausea and vomiting. He was put to bed, and his temperature was found to be elevated to 104°F. Three days prior to admission his neck was noted to be painful and swollen, and he experienced difficulty in swallowing and a choking sensation. He was unable to sleep because of the pain in his neck and sore throat, and his mother left her job to nurse him at home. His temperature elevations continued; his sore throat, dysphagia, and neck pains became more severe, and he was taken to a local hospital. His mother decided, however, to bring him to Children's Hospital, where he was immediately hospitalized with an admitting diagnosis of diphtheria.

He was born in a rural area of Kentucky and



PLATE I

resided in Louisville since 1958. He attended a neighborhood public school. No history of immunizations for diphtheria, tetanus, or pertussis during his life could be elicited from his mother other than oral poliomyelitis vaccine (Sabin) in 1962. His school records (verified by the Jefferson County Board of Health) revealed that his only prophylaxis was a smallpox vaccination in 1959. There was a previous history of varicella, mumps, and pertussis in earlier years without complications.

There were three siblings in excellent health. His mother was employed as a nurse's aide.

On examination, the patient was acutely ill with marked cervical swelling. Blood pressure: 100/80 mm. Hg.; pulse rate: 100; respiratory rate: 16 per minute; temperature: 100.8° F. Examination of the pharynx revealed the presence of a greyish membrane involving both tonsils, posterior pharynx, and uvula. The neck was bilaterally edematous, swollen, painful, and tender. The cardiovascular, pulmonary, and neurological systems were otherwise normal.

The admission laboratory studies revealed a leukocyte count of 25,400 with a preponderance of polymorphonuclear cells; a hematocrit of 49 per cent; and a hemoglobin of 16.7 grams. Urinalysis revealed a

* *Associate Professor of Pediatrics, University of Louisville School of Medicine*

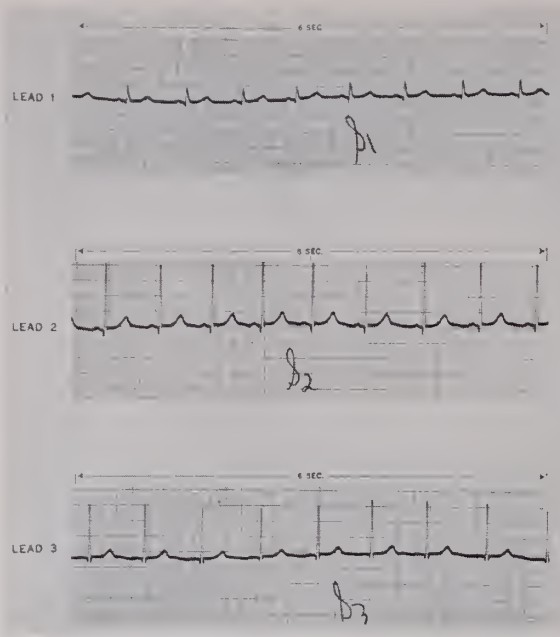


FIGURE 1A—Electrocardiogram taken on second hospital day.

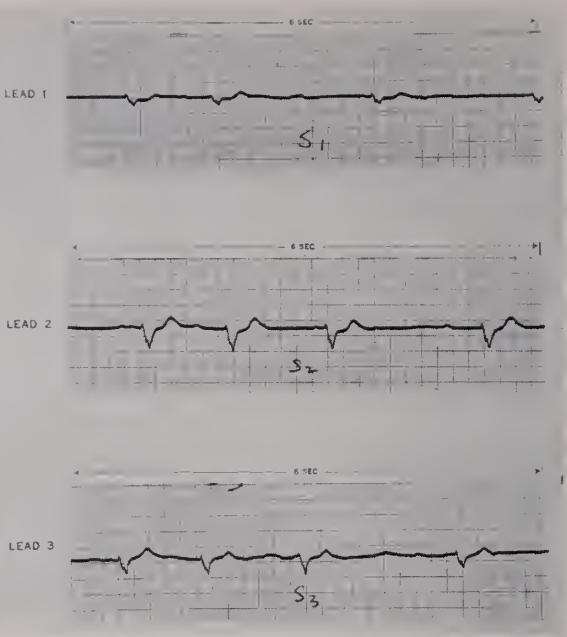


FIGURE 1B—Electrocardiogram taken on seventh hospital day.

trace of albumin and a specific gravity of 1.025. Repeat hemogram continued to reveal a leukocytosis, and repeat urinalysis revealed an albuminuria ranging from large amounts to moderate amounts. A throat smear on admission was reported as negative for C. diphtheriae, and the culture grew out gram positive cocci in pairs and chains; however ,subcultures resulted in the growth of a gram positive bacillus later identified as C. diphtheriae, and a virulence test (guinea pig) was positive. This final report was not available during the period of hospitalization. An electrocardiogram on the second hospital day was normal. A repeated electrocardiogram on the seventh hospital day revealed complete heart block, right bundle branch block, and ventricular fibrillation. An admission chest film was normal and a repeated chest film on the seventh hospital day revealed cardiomegaly and pneumonitis in the left lung field. X-rays of the soft tissues of the neck revealed marked retropharyngeal swelling. (Figures 2A and 2B)



FIGURE 2A



FIGURE 2B

Intravenous hydrating solutions were administered immediately for dehydration and 80,000 units of diphtheria antitoxin were given immediately intravenously followed by Erythromcycin (250 mgm. q. 6 hours). His temperature ranged from 98-101, and the pulse rate 90-100. The blood pressure remained stable, and his respiratory rate was normal. He was kept at strict bed rest. Parenteral fluids were continued daily with Erythromycin. His dysphagia improved, and he could swallow fluids if encouraged. There were several bouts of mild epistaxis easily controlled by pressure. The membrane in the posterior pharynx disappeared, and the prominent swelling of his neck began to regress. His dysphagia never completely subsided, but he could swallow and Erythromycin was given orally on the sixth hospital day. On the eighth hospital day he became restless, apprehensive, and developed signs of impending shock with a fall in blood pressure and a bradycardia. An electrocardiogram disclosed a complete heart block (3:1) and a right bundle branch block. A chest film revealed cardiomegaly and pneumonitis. He was treated for shock with O_2, steroids, blood transfusions, and levophed. A tracheostomy was performed to facilitate his respirations. In spite of these measures he expired.

Autopsy was performed 10 hours post mortem. There was enlargement of the mediastinal lymph nodes with no evidence of mediastinitis. The pericardial sac contained 50-100 cc. of clear fluid. The larynx and upper portions of the trachea were normal. The lower few centimeters of the trachea and major bronchi contained some bloody purulent exudate. All lobes of the lungs were consolidated. The cut surfaces were dark and homogeneous with light pink areas containing nodules of dark red firm tissue resembling pneumonia. Crepitation was reduced throughout all lobes, and consistency was increased.

Microscopically, the mucosa of the trachea was intact with scattering of lymphocytes beneath the epithelium. The bonchus showed a moderate amount of lymphocytes in the submucosa. The blood vessels of the lungs were congested and focal areas of intra-alveolar hemorrhage were present. There were areas of acute pneumonia with neutrophilic infiltrate and some destruction of the pulmonary architecture. The myocardium contained interstitial collections of macrophages and a few lymphocytes. There were areas of degeneration of myocardial fibers with moderate amounts of eosinophiles. The kidney tubules showed areas of degeneration and some evidence of regeneration.

The final diagnosis was:

1. Diphtheria
2. Bronchopneumonia
3. Myocarditis
4. Toxic nephrosis

Comment

This patient was hospitalized with a diagnosis of probable diphtheria based on the presence of a membrane in the posterior pharynx, the enlarged cervical glands giving the appearance of a "bull neck", and the history of no immunizations with diphtheria toxoid. The diagnosis was questioned on the basis of an initial negative throat smear and failure to isolate C. diphtheriae in the initial culture and the rarity of the disease in the present era. The initial culture was reported as positive for gram positive cocci in chains and pairs and a diagnosis of streptococcus pharyngitis was considered most probable. Subcultures on K. Tellurite media finally disclosed the organism to be C. diphtheriae and a virulence test was positive (guinea pig). Treatment was initiated immediately with an adequate dose of diphtheria antitoxin (80,000 units) and continued daily administration of Erythromycin parenterally. Additional evidence supporting the diagnosis of diphtheria was the repeated presence of albuminuria noted in other reports.

The administration of antitoxin (80,000 units) immediately after admission which was five days after the onset of his initial symptoms would appear to be an adequate dosage; however, it should be remembered that the antitoxin will neutralize only that amount of toxin free in the circulatory system and that which will be later absorbed. It has no effect on the toxin already bound by the body cells. The five days elapsing between the onset of symptoms and the adminstration of antitoxin was obviously a factor in the fatal outcome, the mortality rate being reported as 25 per cent if more than four days elapse from the initial onset. Diphtheritic involvement of the myocardium occurs toward the end of the second week of the disease when the patient is considered to be convalescing and sudden death is not unusual. Daily electrocardiograms were not obtained in this patient to provide a clue as to the state of the myocardium. It should be noted, however, that a cardiogram (Figure I) obtained on the second hospital day was normal and frequent observations of his pulse rate disclosed no bradycardia or tachycardia. His respiratory rate was never elevated to suggest congestive heart failure. This patient was maintained on strict bed rest during his period of hospitalization. Since an adequate amount of antitoxin and large doses of Erythromycin were administered parenterally, it is doubtful if any other therapeutic or diagnostic measures would have altered the final outcome.

This case was selected for discussion with the view of alerting physicians that diphtheria has not entirely been eliminated and that diphtheritic myocarditis may develop insidiously and result in a tragic unexpected fatal outcome.

SPECIAL ARTICLES

Here We Go Again!†

DELMAS M. CLARDY, M.D.*

Hopkinsville, Ky.

THERE are forces, and I would call them forces of evil, that would destroy the world's finest medical care. I would also say that these forces are motivated by greed for political power through election of government officials without regard to the consequences.

During the Hoover administration—1928-1932—a committee was appointed to study the cost of medical care. Their report was that the cost of medical care even at that time was excessive. Since that report, there has been a constant effort by some socialistic-minded people in government to socialize medicine and its allied professions.

The Roosevelt era began in 1932, in the midst of the great economic depression, and the Social Security program had its start in 1935. The nation's liberals wanted to include medical care in the program then, but Mr. Roosevelt was not for this. In 1939, Senator Robert F. Wagner of New York introduced a socialistic medical care bill that was not considered by the Congress.

In 1943, a socialized scheme similar to the British plan was introduced and did not receive serious consideration, but was re-introduced by the same sponsors in 1945 in the beginning of the Truman years. It was known as "The National Health Act of 1945." This was a "cradle to the grave" deal patterned closely after the British plan. Congress again took no action. In 1949, the Truman Administration introduced this bill again, but it was to have been tacked onto the Social Security program. This got as far as committee hearings. Apparently a completely socialized program was just too big a dose at one time and the proponents of the scheme didn't push any more until 1957, when Representative Aime J. Forand came up with a real sneaker. This was a broken-dose proposition with a very kind, benevolent, human approach, using the people over 65 years old as pawns. It was this bill that first proposed a certain number of hospitals and nursing home days along with other restricted benefits to over-65 recipients of Social Security benefits. Mr. Forand was said to have admitted that this was a foot in the door, a first step to a completely socialized system. Congress again took no action, so he reintroduced it in 1959. The House Ways and Means Committee held hearings this time and it was rejected by a vote of 17 to 8.

Congressman Forand retired from Congress, but his proposition was continued by Senators Clinton Anderson and John F. Kennedy. In 1960, the Kerr-Mills Law, which we shall discuss later, was enacted. This law was enacted instead of the Kennedy-Anderson bill. In 1961, Senator Anderson and Representative Cecil R. King of California introduced the same bill again, and the committee took no action. In 1962, the liberals in the Senate sought to pass the bill in the Senate by amending a Senate appropriation bill. This was defeated by the Senate by a vote of 52-48. You have no difficulty in seeing what has happened since 1928 when Congress would not consider such legislation, to 1962, when the Senate rejected the bill by only four votes. Losing doesn't bother these people; they come right back as strongly, or stronger, than ever. If we lose once, we are finished!

So here we go again. The King Anderson HR 3920 was once again introduced in the 88th Congress in January 1963 and January 1964. Our own Senator Cooper of Kentucky, Senators Javits, Case, Keating, Kuchel and Smith introduced Senate Bill 2431. The two are almost the same, except that 2431 carries provisions for more complete medical care for those over 65. Both are financed by the increase of Social Security taxation of about $100 per year for each employed person, to pay about one-fourth the total medical care costs of those over 65, most of whom could pay their own way.

Such legislation involves basic American concepts of government and the rights of a dynamic, progressive system of medicine to remain free to continue its service to mankind, unfettered by bureaucratic controls.

The socialistic proponents have woven into their arguments tattered fabrics of misrepresentation, half-truths, and outright misstatement of facts, ignoring the central issues. The warmhearted sympathies of the good citizens of this country and their willingness to aid the unfortunate have been stirred on wholly false grounds. They arouse confusion in the minds of many who are honestly trying to reach a conclusion as to the right and wrong of what has been proposed. Emotion has been substituted for reason and the people are being deceived.

†Edited version of a speech to a regional meeting of the Students Branch of the American Pharmaceutical Association at the University of Kentucky February 1964.

**President of the Kentucky Medical Association, 1964-65.*

Who wants this sort of thing and why? There are two distinct groups. First, there are the politicians who see this as an attractive vote-getting scheme. They would buy the votes of the nation's 17-and-a-half million elderly citizens by taking credit for offering them tax-supported medical care, whether they need it or not. At the same time, there is appeal to the sons and daughters by giving them the opportunity to shift responsibilities for their aging parents to the government.

The other supporters are the power-hungry bureaucrats and the crusaders who are forever trying to rescue society from difficulties which only they can see. In their own minds, they are the elite corps which is much more capable of making decisions for the people, as in the case of health care, then the people themselves. This, of course, includes spending the citizens' money, which they do not trust the people to spend prudently.

How have these socialists gone about this subversive plan? (When I say "Socialists," I am not speaking specifically of the names that appear as the sponsors of these socialistic bills. We believe that other persons who have the real basic information of the socialistic philosophy and with real objective in bringing about total socialism, wrote all of these bills.) They have deliberately based their campaign on a claim that the aging population is an underprivileged, unhealthy, and mistreated group that doctors don't like. This is a most atrocious falsehood. On the contrary, the medical and its allied professions have made it possible for many people to live past the age of 65.

There are about 18 million people in this country over 65. One half million of them are wealthy, and 9-and-a-half million have private health insurance and manage well with incomes from savings, stocks, bonds, other investments, annuities, soldiers' pensions, social security, and other income. These people are certainly not entitled to free hospital or any other care at the expense of people who are working and having a hard time supporting their own families. Most of them don't really want to be beneficiaries of such an unfair scheme. From experience with my own patients over 65, I know this to be true. They resent being singled out as a problem and a burden to the nation. There are many useful citizens over 70 or even 75. Some of the world's greatest people are classified as aged. Sir Winston Churchill did not become Prime Minister of Great Britian until he was 69. Chancellor Adenauer of West Germany was much past 80. President DeGaulle of France is about 75 now .

There are about seven million people over 65 who are less fortunate. In fact, there are just as many under 65 who are just as unfortunate. Everyone knows this is true, and everyone knows also that the aged, as well as the younger unfortunates, are being taken care of through the great generosity of the people, which includes us.

You can tell your families, your friends, and everyone else that the needy aged in most states are already being cared for through the Kerr-Mills Act. Through this law, each state sets up its own program sufficient to the needs of its people and the program is carried out and controlled at the local and state levels. You can tell them that the program in Kentucky is a success. I believe it is just as successful in the other states that have seen fit to put it into operation.

This success has been achieved in spite of much opposition from the proponents of King-Anderson, mostly from the federal level, who have talked loudly about the shortcomings and even failures of the Kerr-Mills plan. They have had the assistance of some newspapers who seem to think they have great knowledge of the whole problem, and who make glaring statements of misinformation and untruths.

Kerr-Mills has some drawbacks, it is true. Druggists must have copies of prescriptions, and are allowed a close margin of profits on the drugs. However, this is much better than having the entire business controlled from Washington, which will happen if we are socialized.

The socializers also claim that King-Anderson is an insurance program that won't cost much. This is completely false. Social Security itself is not an insurance program and the addition of health care would not make it so. It is a tax program; no more, no less, and has been declared just that by the Supreme Court. There is no back-log of reserve insurance money. The present day demands are met by the present day current taxation. If there is a deficit, and there has been, the tax bite is increased. In 1937 the combined employer-employee tax take was two per cent on the maximum of $3,000. At the present time it is seven and a quarter per cent on $4,800 and in 1968 it will be nine and a quarter per cent. If this so-called "Medicare" law is passed, another half per cent will be added and the maximum taxed will be increased to $5,200, which is a 16 per cent increase in the social security tax. This means about $100 extra per year for every working person in the country, to be given to 10 million people who don't need it, and would not have contributed one cent for it. This is the cost that is calculated by the planners, but the private insurance company actuaries say that four times that amount would be nearer the correct figure.

"Medicare," the publicized title of this plan, is also misleading. The law would not include medical care. It would call for hospital and nursing home care and would cover only about a quarter of the total cost. This wouldn't give much help to a person who was unable to help himself. Perhaps they use the term because it would eventually lead to a total medical care scheme.

The backers of the proposition say that it is not socialized medicine and would not lead to it. I say that it *is* socialized medicine and will lead to the destruction of the finest medical care in the world, as it has done in what were formerly the great medical centers of Europe. If this law is enacted, more amendments to the Social Security laws would be forthcoming, to include more care for more people and finally, it would be complete. This was admitted by Mr. Forand and by Mr. Norman Thomas, who in the past has been the chronic Socialist candidate for President. It would be no different from the situation in the European countries who have been going through this for about 80 years. Once, American doctors went

to Europe for post-graduate training. Vienna, Austria, was particularly a favorite spot. But all this has changed. Their doctors come here to study or to stay, and most of them stay. Talk to the British physicians, of whom there are many in this country, and a number in Kentucky. They will tell you without hesitation what has happened and is happening in Britian since 1948 when their National Health scheme went into effect.

This thing will hit students of pharmacy three ways. Many of you will own drugstores and will hire many people. You will pay the employers' tax, plus your self-employed tax and your business will be controlled by any legislation that is passed. You that become employed will have money withheld from your pay to give someone who probably does not need it, or even want it. We are all in the boat together. The public thinks the doctor is the most concerned, but he isn't. You, our friends, are also vitally involved.

Now, what can we do about it? We could say, and truthfully, that we would not cooperate and would have nothing to do with these subversive doings. If enough of us did, the whole idea would fall on its face. My British friends tell me that if we don't want it we don't have to have it, meaning non-cooperation. But we are told that such an action would alienate our friends, of whom we have many, and we should not think of such a thing. Instead, I believe we should pass along the truth and do our jobs in conscientious manner; that the people will take care of us. We can let our lawmakers know how we feel, and have our friends and relatives let them know how they feel. Then at election time, we could discuss the matter with our candidates who are sensitive to public opinion, especially to majority opinions.

A great American patriot once wrote: "I am only one, but I am one. I can't do everything, but I can do something. And what I can do, I ought to do. And what I ought to do, by the Grace of God, I shall do."*

**Ethan Allen*

March 18, 1965

KMA Interim Meeting—Owensboro

Gabe's Restaurant

You are urged to attend this important meeting!



We Owe A Debt

THERE came by mail recently an announcement from one of the pharmaceutical manufacturing concerns of the establishment of an annual $1,000 scholarship for one medical student in each of the 88 medical schools in the United States. These scholarships have been provided during the past four years and in addition the same company has contributed $100,000 a year for the past two years to the American Medical Association's Educational and Research Foundation for its student loan guarantee program.

We received today from the Pharmaceutical Manufacturers' Association their roster of 126 drug manufacturing companies. These are reputable firms who have national distribution of their products and most of the names are quite familiar to us. Many of these companies have contributed just as liberally and over as long a period of time to medical education as has the one cited above. All have contributed in varying measures in similar manner.

The philantropy of these manufacturers is not at all limited to scholarships and loan funds. Many of our best post-graduate courses are subsidized by them. Seminars, regional, district and even county medical society meetings are assisted generously by these concerns. Traveling expenses of participants in the program; material such as charts and pictures; visual and auditory aids are often provided upon request. It is not an entirely unheard-of feature that the refreshment hour may be sponsored by a drug manufacturer.

In many of our medical centers during the past few years the local medical society has sponsored a senior day program in which the members of the senior class of the local medical school are guests for a day and for an evening. Sponsorship of this activity has often been part of the contribution by a local or regionally located pharmaceutical house. Scientific essay contests with prizes of sufficient worth to attract eager participation among medical students is another activity sometimes publicized.

Aside from these very considerable contributions for which the drug concern receives ample recognition, there are many lesser projects sponsored locally designed to promote the improvement and expansion of medical, nursing, pharmacy, medical assistants, and other para-medical activities which are subsidized by our friends. Contribution of liberal supplies of drugs for use in hospitals—not for experimental purposes but for indigent patients—are often made without reservation and without even the knowledge of the recipient whose life may be saved.

Acknowledgement for financial support to medical progress must be extended far beyond the research laboratories and the manufacturing houses of pharmaceuticals. The AMA's Foundation for Education and Research has received regularly both large and small contributions during the past ten years from many business concerns and individuals not at all related to medicine or pharmacy. These funds have been substantially increased by the regular gifts of physicians and their personal friends.

National Foundations have for generations supported Public Health, Hospitals and Medical Research. Their contributions are enormous. Innumerable smaller private foundations in every state and city have given liberally of their accumulated surplus to build and equip medical schools and hospitals and provide professional service to the indigent. This is the American way of life—the freewill offering of capitalism, if you please, to human welfare.

Federal and state governments have shared increasingly in the provision of health care to all people. The very considerable contributions to research and medical care through The National Institutes of Health, the government-supported Veterans' facilities, and the Armed Serv-

ices, constitutes a large percentage of our medical achievement.

Thus the two hundred thousand physicians in the United States become partners in the enormous enterprise of medical care. True, we play the leading role—we are the sine qua non —the spearhead and the cutting edge of the whole health machine. By hard and honest work we earn a living and a place of high public esteem for ourselves and our families. But we must not forget the necessity of our supporting cast for the moral and financial help that we must have to function as we are supposed.

This support we gratefully acknowledge and express the hope that our conduct as a profession may merit the continuation of confidence and esteem and the moral and financial bounty of our friends.

SAM A. OVERSTREET, M.D.

Sharing the Load

IT is most gratifying when one reviews the recent history of the Kentucky Medical Association to observe the progress that has been made. The volume of services rendered by the Association each year to the public and our members increases at a surprising pace. It is worth considerable thought as to what the future might hold as our achievements continue to grow and benefit both the profession and Kentucky's citizens.

This, of course, has been accomplished only through the hard work of our members and has required many devoted hours. Our Association has grown from a few committees a short time ago to the approximatly 60 committees we have today on which nearly 400 KMA members serve. Last year these physicians traveled over 100,000 miles to attend committee meetings at which they spent more than 2100 hours in these meetings alone. It is difficult to find appropriate words to express our gratitude to them.

Yet, as we scan our committee rosters, we sometimes wonder if we overwork and overload our experienced men who are always willing to accept responsibility in KMA. Similarly, this makes us wonder if we have overlooked young physicians who are willing and able to be trained to assume positions of responsibility. We are a growing organization, requiring many diversified talents.

Doctor George Archer perceived this during his tenure of office as KMA president. In his President's Report to the 1964 House of Delegates, he recommended that the Board of Trustees, in all cases possible, limit the appointment of each member to one committee position as a matter of general policy. The endorsement of this recommendation concurs with our desire for continued betterment of KMA. Your endorsement is reflected by your willingness to serve and assume an active role in organized medicine.

R. G. C.

ORGANIZATION SECTION

Thirteenth District to Meet In Ashland on Apr. 6

The Thirteenth Trustee District will hold its annual meeting Tuesday, April 6 in the Henry Clay Hotel in Ashland, Walter L. Cawood, M.D., Trustee from Ashland, has announced.

"The Key to Socialism" will be discussed by KMA president Delmas M. Clardy, M.D., Hopkinsville, who is the featured speaker. The Boyd County Medical Society will act as host.

The Thirteenth District includes the following counties: Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan and Rowan.

Drs. Hodgkinson, Smith Featured On Ky. Ob-Gyn Society Program

C. Paul Hodgkinson, M.D., Detroit, and Kaighn Smith, M.D., Philadelphia, will be the key guest speakers at the Kentucky Obstetrical and Gynecological Society meeting April 1-2 in Lexington, Edwin P. Solomon, M.D., Louisville, Society president, announced recently.

Doctor Hodgkinson, chairman of the department of obstetrics and gynecology at Henry Ford Hospital, will speak on "Extra-uterine Pregnancy" at the Thursday morning session.

Doctor Smith will present two papers on Friday morning, April 2, entitled "Hysterosalpinography and the Incompetent Cervix", and "Placental Localization". He will also participate in a panel discussion on "Tumors of the Ovary". Doctor Smith is associate in obstetrics and gynecology at the University of Pennsylvania School of Medicine.

The meeting, at the University of Kentucky Medical Center, will be held this year in conjunction with the U.K. department of radiology's symposium on Genito-Urinary Disease. Members of the College of Medicine faculty from U.K. will present other papers at the sessions.

Doctor Solomon said that the Society will present its annual prize at 2:00 p.m. on Friday, for the best paper submitted by obstetrical and gynecological residents in the state. The winning paper will be read at that time. The group will hold its business meeting at 2:45. A dinner-dance will be held the evening of April 1.

AMA House Holds Special Session Feb. 6-7 to Review Medicare

Delmas M. Clardy, M.D., KMA president from Hopkinsville, and KMA delegates to the AMA, Wyatt Norvell, M.D., New Castle; J. Thomas Giannini, M.D., Louisville; and John C. Quertermous, M.D., Murray, were among the representatives of KMA attending the special session of the House of Delegates of the American Medical Association meeting February 6 and 7 in Chicago.

Meeting to review current health care legislation, the House of Delegates gave unanimous approval and support to the AMA Eldercare Program and to the Herlong-Curtis Eldercare bill (H.R. 3727), which embodies the basic principles of the AMA program.

In acting upon six resolutions and reports from the AMA Board of Trustees, Council on Legislative Activities, and Council on Medical Service, the House also!

1. Reaffirmed its opposition to the King-Anderson bill (H.R. 1 and S. 1) and all similar measures;
2. Commended the Board of Trustees and its Task Force for implementing and funding a program of public education on the AMA Eldercare Program and gave them a standing vote of confidence;
3. Called for study of the "desirability and feasibility of extending the principle of federal and state aid under the Kerr-Mills principle to persons below the age of 65 who need help";
4. Adopted a statement on Standards for Health Care Programs, and
5. Urged that the professional services of pathologists, radiologists, physiatrists and anesthesiologists should be excluded from the provisions of any bill which excludes other physicians' services.

Be Sure to Attend —

KMA Interim Meeting—Owensboro

March 18, 1965

also

Open meeting of House of Delegates—Owensboro

8:00 p.m. March 17, 1965 — Both at Gabe's Restaurant

Ky. College of Surgeons Meeting Set Apr. 9-10 in Paducah

Five Distinguished guest speakers will participate April 9 and 10 in the annual assembly of the Kentucky Chapter of the American College of Surgeons at the Holiday Inn in Paducah, according to Robert W. Robertson, M.D., Paducah, Chapter president.

Appearing on the program will be Bentley P. Colcock, M.D., department of surgery, Lahey Clinic, Boston; Langdon Parsons, M.D., professor of gynecology at Boston University School of Medicine; and Claude Welch, M.D., associate professor of surgery at Harvard and chief of the Tumor Clinic at Massachusetts General Hospital.

Marcus Stewart, M.D., associate professor of orthopedic surgery at the University of Tennessee School of Medicine, Memphis, and James H. Spencer, M.D., assistant administrator of the American College of Surgeons, Chicago, will also speak.

Doctor Robertson released the following complete program:

Friday April 9, 1965

8:00 **Registration:** Assembly Room, Holiday Inn, R. W. Robertson, M.D., Moderator

9:00 **Neurovascular Disorders of the Upper Extremity Treated by Transaxillary Sympathectomy,** Harold E. Kleinert, M.D., Louisville

9:20 **Infant Hernias.** Bernard J. Schoo, M.D., Louisville

9:40 **Neurosurgical Aspects of Metastatic Carcinoma.** Charles Wilson, M.D., Lexington

10:00 **Retained Gastric Antrum, Simulating the Zollinger-Ellison Syndrome.** George Sanders, M.D., Louisville

10:30 **Safeguards in Surgery of the Stomach and Duodenum.** Claude Welch, M.D., Boston, Massachusetts

11:00 **Management of Fractures, Lower Third of Femur.** Marcus Stewart, M.D., Memphis, Tennessee

11:30 **The Combination of Radiotherapy and Surgery in Treatment of Cancer of the Head and Neck.** Benjamin F. Rush, M.D., Lexington

11:50 **Application and Proper Interpretation of Venous Pressure in the Management of Shock.** Mohammad Atik, M.D., Louisville

12:30 **Fellowship Luncheon** Holiday Inn
Remarks by the Governor and First Vice-President, American College of Surgeons, Rudolph J. Noer, M.D., Louisville

2:00 **Extracorporeal Liver Profusion in the Treatment of Clinical Hepatic Coma.** Johan VanWyk, M.D., Liem Djie Swie, M.D., and Ben Eiseman, M.D., Lexington

2:20 **Intersex.** Eli Khouri, M.D., Paducah

2:40 **Pitfalls in Diagnosis and Treatment of Carcinoma of the Ovary.** Langdon Parsons, M.D., Boston, Mass.

3:15 **Regional Enteritis.** Bentley Colcock, M.D., Boston, Mass.

3:45 **Polyps of the Stomach in Children.** W. B. Haley, M.D., Paducah

4:00 **A Method of Closed Thorocostomy.** Theodore Myre, M.D., Paducah

6:00 **Social Hour.** Paducah Country Club

7:30 **Dinner and Dancing.** Speaker: James Spencer, M.D., Chicago **"The Kentuckians."**

Saturday April 10, 1965

7:30 **Executive Breakfast Meeting,** Holiday Inn. (Officers and Members of Council) Charles Edelen, M.D., Moderator

9:00 **Surgical Experiences in Vietnam.** Charles Kissinger, M.D., Henderson

9:30 **Athletic Injuries·** Marcus Stewart, M.D., Memphis, Tenn.

10:00 **Panel—The Patient with a Pelvic Mass.** Doctors Colcock, Parsons, Welch. Panel Leader: Arnold Griswold, M.D., Louisville

11:00 **Business Meeting** (Members Only)

12:30 Buffet Luncheon at home of Doctor and Mrs. Robert Robertson.

Help Your Society Secretary

"If you have not already done so, assist your County Medical Society sercetary by remitting your county, state, and AMA 1965 dues promptly," urges Delmas M. Clardy, M.D., KMA president, adding, "Your County secretary is a busy man, too." Bylaws provide that dues remaining unpaid by April 1 be considered delinquent.

Drs. Hahn, Keller Featured On Senior Day Programs

Harvey C. Hahn, D.D., pastor of the Otterbein Evangelical United Brethern Church, Dayton, O., and William K. Keller, M.D., professor and chairman of the department of psychiatry at the University of Louisville School of Medicine, will be the featured speakers at KMA's traditional Senior Day programs at U. of L. and U. of K., respectively.

Doctor Hahn will address the senior class at the University of Louisville School of Medicine on "Burnt Matches" March 13. Doctor Keller has chosen the topic, "Why Not?" for his talk before University of Kentucky seniors April 15. Doctor Hahn's appearance is sponsored by General Motors.

Each program is being presented by KMA in cooperation with the medical school and the medical society of the county in which the school is located.

Delmas M. Clardy, M.D., KMA president, will open both sessions with a talk on "The Great Society of Mediocrity". Other speakers will discuss socio-economic topics of interest to the student who is soon to enter practice.

Dr. Lich Named to Urology Post

Robert Lich, Jr., M.D., Louisville, has been elected vice-president of the nine-member American Board of Urology, which examines candidates seeking certification in urology. Doctor Lich, who is clinical professor of urology at the University of Louisville School of Medicine, is serving his seventh year of a nine-year term on the Board.



The Doctor's Visit, Jan Steen 1626-1679, Mauritshuis, The Hague

In Diverticulosis and Diverticulitis...

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"Diverticulosis ... a low-roughage diet is advisable.... Constipation is avoided, preferably by the daily use of Metamucil.

"Diverticulitis Mild, chronic symptoms of diverticulitis, such as diarrhea or flatulence also are treated[1] by low-roughage diet, adequate fluid intake and Metamucil...."

Usual Adult Dosage: One rounded teaspoonful of Metamucil (or one packet of Instant Mix Metamucil) in a glass of cool liquid one to three times daily.

Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

SEARLE

Research in the Service of Medicine

Dr. Meyer Named to Health Post

Dexter E. Meyer, Jr., M.D., Covington, was appointed February 8 by Governor Edward T. Breathitt to serve on the State Board of Health. Reappointed at the same time was Branham B. Baughman, M.D., Frankfort.



Doctor Meyer

Doctor Meyer will fill the position vacated by Robert W. Robertson, M.D., Paducah, who was ineligible, under the policy of the KMA Board of Trustees, for nomination. According to the Kentucky Revised Statutes, the KMA Board nominates three physicians for each vacancy on the Board of Health. It is the policy of the KMA Board that no physician be nominated for more than two terms, in succession.

Rural Medical Scholarship Fund Creates New Two-Phase Plan

The Rural Ketucky Medical Scholarship Fund has formulated a new program designed to encourage more young physicians to locate in ten Kentucky counties critically in need of physicians, according to C. C. Howard, M.D., Glasgow, chairman of the Fund's Executive Committee.

At its January 27 meeting at Louisville, the Executive Committee created the new two-part loan program directed toward assisting new physicians to set up practice in the "critical" areas, and aiding students entering the medical schools of the state.

A young physician entering practice in one of the ten critical counties will now be able to contract with the Fund for a loan of $2,000, payable in one, two, three and four years, for the purpose of establishing a practice. One $500 portion of the loan would be cacelled for each year he remained in the county in question. The arrangement is applicable to present Scholarship Fund recipients.

The second part of the plan offers the prospective medical student a loan of $2,000 a year for each of the four years in school, provided the student will contract to locate in one of the critical counties, Doctor Howard said. One year's loan will be cancelled for each year he remains in practice in the critical county.

"Critical" couties are determined each year by the Board of Trustees of the Fund, with the help of the records of KMA and the State Department of Health. The critical counties currently listed by the Fund are: Breathitt, Elliott, Knott, Lee, Leslie, Magoffin, Martin, Owsley, Powell, and Wolf.

Eight New Members Announced By KMA as of Feb. 15

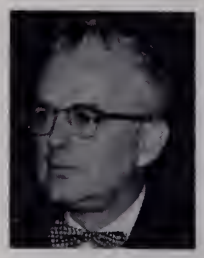
Eight Kentucky physicians have become new members of the Kentucky Medical Association, according to the KMA membership department records dated February 15.

Among the new members are Mohammad Atik, M.D. and Paul A. Keeney, M.D., Louisville, and James F. Rold, M.D., and Gerard A. Weigel, both of Somerset.

Others are: Thomas D. Brower, M.D., Lexington; Robert B. Chambliss, M.D., Burkesville; James E. McAfee, M.D., Horse Cave; and William Yates, M.D., Bloomfield.



Doctor Bosworth



Doctor Asman

New KMA Judicial Council Meets First Time; Chooses Chairman

The new KMA Judicial Council, meeting officially for the first time January 28 at the Headquarters office, elected N. Lewis Bosworth, M.D., Lexington, as its chairman.

Henry B. Asman, M.D., Louisville, KMA secretary, will serve also as secretary of the Council. E. Gaines Davis, general counsel for KMA, will staff the meetings.

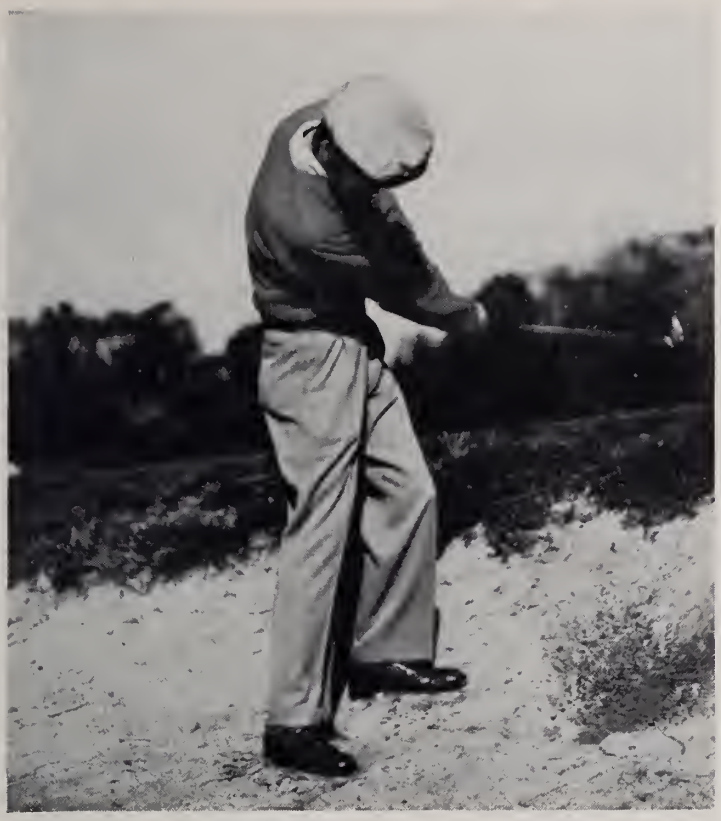
The Judicial Council, created by an act of the House of Delegates at the 1964 Annual Meeting, will be the Board of Censors of the Association. Questions of an ethical nature brought before the Board of Trustees will be referred to the Council without discussion.

The Council will be the final judge of the right and standing of members, and of disciplinary action, and will have the right to intervene in or supercede the disciplinary proceedings of any county, individual trustee, or district. However, all problems should be handled at local or district levels if possible.

At the January 28 meeting procedures were set up for handling regulation matters. Guidelines are being drawn up for more intricate problems.

Other members of the Council are Clyde C. Sparks, M.D., Ashland, J. Duffy Hancock, M.D., Louisville, and Hugh L. Houston, M.D., Murray. Under the terms of the KMA Bylaws, one member is chosen from each of the eastern, western, and central sections of the state, and one from the state at large, plus the secretary of the Association.

In order to activate the Judicial Council so that it might function this year, the House gave the Board of Trustees authority to make the present interim appointments to serve until the 1965 meeting. At that time the members of the Council will be elected by the House of Delegates, with terms being staggered as provided in the Bylaws.



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Also available as 'Soma' Compound with Codeine: carisoprodol 200 mg., phenacetin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning: may be habit-forming.)

(Warning: Codeine may be habit-forming.) **Indications:** 'Soma' Compound and 'Soma' Compound with Codeine are useful for relief of pain and stiffness in traumatic, rheumatic and other conditions affecting muscles and joints. **Contraindications:** Allergic or idiosyncratic reactions to carisoprodol, phenacetin, or codeine phosphate. **Precautions:** *Phenacetin*—With long-term use, give cautiously to patients with anemia and cardiac, pulmonary, renal or hepatic disease. May damage the kidneys when used in large amounts or for long periods. *Caffeine*—Not recommended for persons extremely sensitive to its CNS stimulating action. *Codeine phosphate*—Use with caution in addiction-prone individuals. *Carisoprodol*—Carisoprodol, like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g. meprobamate. **Side effects:** Drowsiness, lightheadedness, dizziness, and gastric complaints have been reported infrequently for either or both of these preparations. *Phenacetin*—Side effects are extremely rare with short-term use of recommended doses. Prolonged ingestion of overdoses may produce dyspnea, cyanosis, hemolytic anemia, skin rash, anorexia, subnormal temperature, insomnia, headache, mental disturbances, and tolerance. *Caffeine*—Side effects are almost always the result of overdosage. Average doses may rarely cause nausea, nervousness, insomnia, and diuresis. Excessive dosage may produce, in addition, restlessness, nervousness, tolerance, tinnitus, tremors, scintillating scotomata, tachycardia, and cardiac arrhythmias. *Codeine phosphate*—Possible side effects are nausea, vomiting, constipation, and miosis. *Carisoprodol*—The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms. One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross-reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reaction, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression. **Dosage:** Usual adult dosage of 'Soma' Compound or 'Soma' Compound with Codeine is one or two tablets three times daily and at bedtime. **Supplied:** 'Soma' Compound, orange tablets, each containing carisoprodol 200 mg., phenacetin 160 mg., and caffeine 32 mg. 'Soma' Compound with Codeine, white capsule-shaped tablets, each containing carisoprodol 200 mg., phenacetin 160 mg., caffeine 32 mg., and codeine phosphate 16 mg. Narcotic order form required. *Before prescribing, consult package circular.*

CSO-6114

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MEDICAL SCHOOL NEWS

Ob-Gyn Staff at U. of K. Gets Two New Members

John W. Roddick, Jr., M.D., and Bernhardt L. Pederson, M.D., has joined the staff of the department of Obstetrics and Gynecology at the University of Kentucky Medical Center making complete the complement of personnel of that department.

Doctor Roddick, appointed an associate professor, came to the University from Northwestern University Medical School in Chicago, where he received his M.D. in 1950 and an M.S. in gynecology and pathology in 1955. Doctor Pederson, an instructor in the department, is a 1959 graduate of the University of Michigan Medical School. He was a teaching associate and resident from 1961-64 at that school.

At the time of announcing the above appointments, the Medical Center also announced that its hospital had received three-year accreditation from the Joint Committee on Accreditation of Hospitals.

The Board of Trustees has approved the appointment of Wilmier M. Talbert, Jr., M.D., as assistant professor in the department of pathology. Additional appointments have been approved for: Michael L. Furcolow, M.D., to professor of pediatrics, and W. F. Yates, M.D., to clinical assistant in pediatrics. Doctor Furcolow is also professor of community medicine, and Doctor Yates is a part-time physician with the University Health Service.

Grants Given For Eye Research

Two grants totaling $11,000 have been awarded to the University of Louisville School of Medicine for use in eye research, according to C. Dwight Townes, chairman of the department of ophthalmology.

The Kentucky Lions Eye Foundation awarded $6,000 and the Research to Prevent Blindness, Inc., $5,000. Both grants are unrestricted, Doctor Townes said.

KAGP to Meet May 5-7 In Louisville

Two University of Louisville Medical School graduates will be among the distinguished guest speakers scheduled to appear on the program of the Kentucky Academy of General Practice Annual Meeting May 5-7 at the Kentucky Hotel in Louisville.

Thomas P. Kearns, M.D., of the Mayo Clinic, Rochester, Minn., graduated in 1946 from U. of L., and John W. Yarbro, M.D., St. Paul, a member of the University of Minnesota faculty, was a member of the 1956 graduating class.

Also on the program will be: George E. Moore, M.D., director of Roswell Park Memorial Institute, Buffalo, N.Y.; Robert L. Egan, M.D., Emory University, Atlanta, Ga.; Theodore N. Guiglia, M.D., University of Kentucky College of Medicine; Joseph Eschbach, M.D., Seattle Artificial Kidney Center; Sheldon G. Sheps, M.D., Mayo Clinic; and Neil W. Swinton, M.D., Lahey Clinic, Boston, Mass.

Dr. Archer on Foundation Board

George P. Archer, M.D., Prestonsburg, immediate past president of KMA, was named by the Board of Trustees of the American Medical Association to serve four years on the Medical Advisory Board of the Sears-Roebuck Foundation.



Doctor Archer

Doctor Archer will begin his term after AMA's Annual Convention in June, with four other physicians appointed at the same time. The board acts as an advisory group for the Foundation's Community Medical Assistance Program.

Pediatricians' Joint Meeting Set May 12-13 in Ashland

The Kentucky Chapter of the American Academy of Pediatrics and the Kentucky Pediatric Society will have as their guest Harry C. Shirkey, M.D., Birmingham, authority on pediatric toxicology, at the May 12-13 joint meeting to be held at Bellefonte Country Club in Ashland.

Doctor Shirkey is professor of pharmacy at Howard University and assistant professor of pediatrics at the University of Alabama. He is also director of Childrens' Hospital, Birmingham.

According to Guy C. Cunningham, M.D., Ashland, program chairman, who released the tentative program for the meeting, the first scientific session will begin at 1:30 p.m., Wednesday, May 12. A panel discussion entitled "Evaluation of Blunt Trauma", will be the first presentation. Panelists are to be William W. Johnson, M.D., and Lawrence A. Davis, M.D., both of Louisville, and Richard A. Segnitz, M.D., Lexington.

"Experiences With Genetic Counseling", by C. Charlton Mabry, M.D., Lexington, will be followed by a brief business meeting for members of the Pediatric Society.

Thursday's scientific session will start at 9:30 a.m. with Doctor Shirkey's presentation on "Drug Therapy in Children". A discussion period, led by Warren E. Wheeler, M.D., Lexington, will follow.

Following a coffee break, Doctor Davis will discuss "Some Pertinent Pediatric Problems—X-Ray Aspects". A short business meeting for Academy members will then be held. Adjournment is scheduled for 12:30 p.m.

Various recreational and social activities have been arranged during the meeting, Doctor Cunningham said, including golf, a social hour and dinner, and a country ham breakfast on Thursday morning.

The number of accredited hours to be alloted to general practitioners attending the meeting has not yet been decided by the American Academy of General Practice.



…y you a cup of coffee?



Fine! This last patient…



Mrs. Jones?



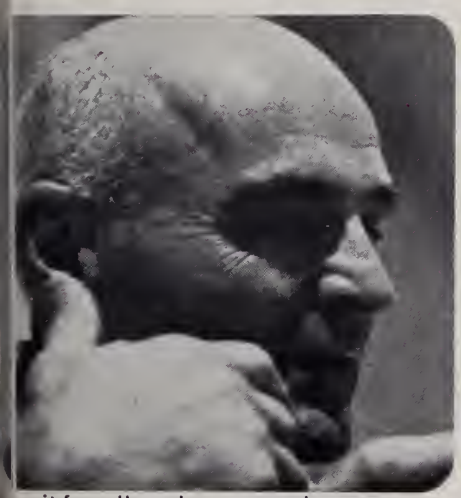
…s, sir. She's down to 140/85.



Right. When we started, she was 195/120.



Is that Regroton again?



…se it for all my hypertensives.



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C…position: Each tablet contains chlorthalidone, 5…g., and reserpine, 0.25 mg.
C…traindications: History of mental depression, h…ersensitivity, and most cases of severe renal o…epatic diseases.
W…ning: Discontinue 2 weeks before general a…sthesia, 1 week before electroshock therapy, a… if depression or peptic ulcer occurs.
P…cautions: Reduce dosage of concomitant anti-h…ertensive agents by one-half. Discontinue if th… BUN rises or liver dysfunction is aggravated. E…ctrolyte imbalance and potassium depletion m… occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

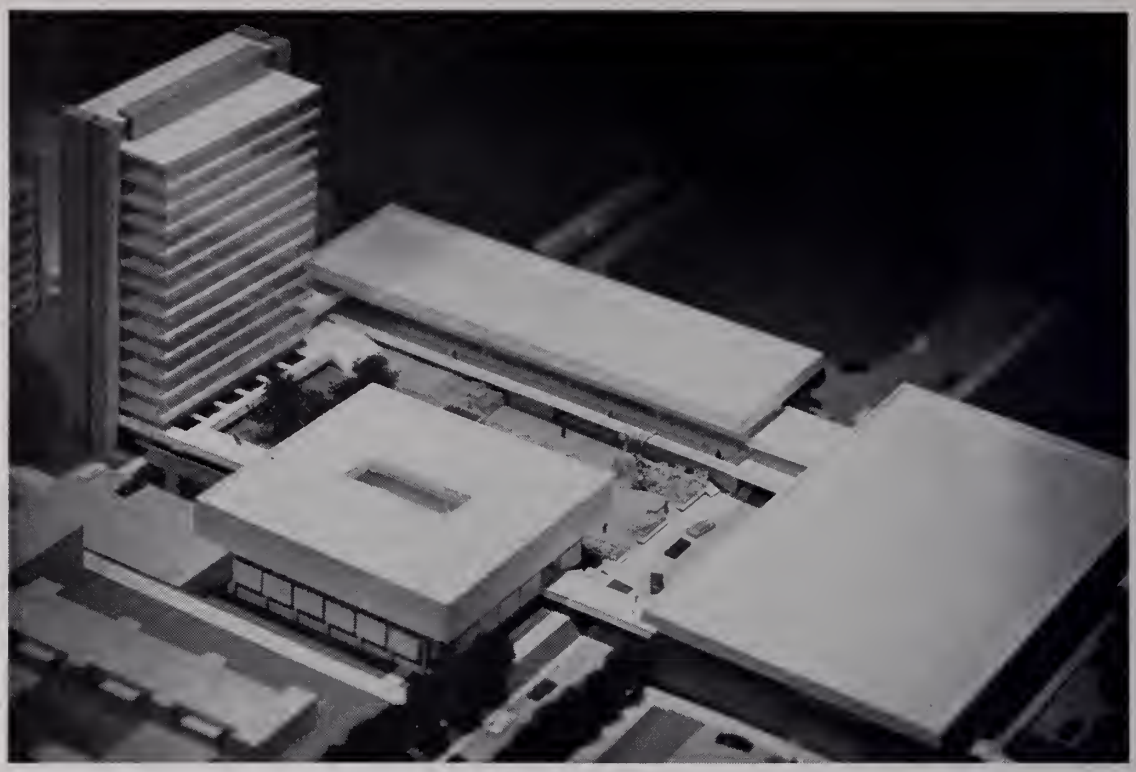
Availability: Bottles of 100 and 1000 tablets.
Average Dosage: One tablet daily with breakfast.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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The four buildings which would comprise the proposed new $24 million U. of L. Medical-Dental Education and Research complex are pictured above in an architect's model. The tall building will serve as an office and research building for the medical school. To its right is the medical instructional building with the library opposite. At bottom right in the picture is the dental school. The buildings will be connected by open and closed concourses.

U. of L. Plans $24 Million Medical-Dental Complex

A four-unit, $24 million education and research complex planned for the University of Louisville Medical and Dental Schools was announced January 21 by U. of L. President Philip Davidson.

It is hoped that the project can be financed on a 50-50 basis by the Federal government and State and local bond issues. Application for federal funds will be made before April 1, and a portion of the State money is to come from part of a State bond issue of $176 million which will be voted upon in November of this year.

The complex, called the largest single project ever undertaken by the University, would include four buildings in a quadrangle to be located at the corners of Preston and Walnut Streets, just to the rear of General Hospital.

The quadrangle would include a three-story medical instruction building, a 14-story medical office and research building, a three-story library-auditorium, and a three-story dental instruction building.

Doctor Davidson said that the facility would enable the School of Medicine to graduate 120 students a year and the Dental School 80 compared to the present 60. Construction would begin a year from now, with completion scheduled for five or six years from that time.

Kentucky Surgical to Meet in May

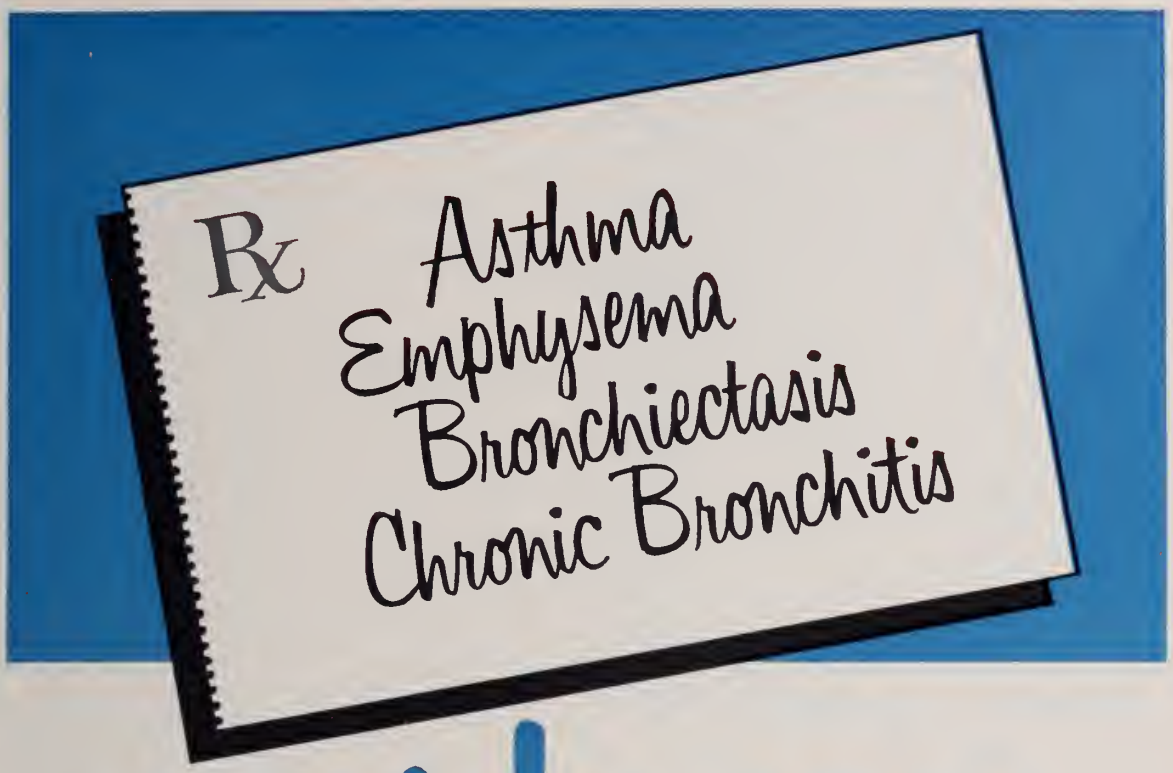
The Kentucky Surgical Society, meeting May 14-15 in Louisville, will have as its guest speaker Robert J. Samp, M.D., assistant professor of surgery and director of the division of clinical oncology at the University of Wisconsin Medical Center.

Rudolf J. Noer, M.D., professor and chairman of the University of Louisville School of Medicine department of surgery, will be in charge of Friday's all-day program at U. of L. The meeting is being held this year in cooperation with the department of surgery. Headquarters for the meeting will be the Brown Hotel.

Health Dept. to Aid SS Program

The Kentucky State Department of Health has been appointed by Governor Edward T. Breathitt to coordinate the new Selective Service Rejectees Informational Program for Kentucky, announced Russell E. Teague, M.D., Commissioner of Health.

Kentucky is expected to receive from $60,000 to $100,000 a year for the program under recent congressional appropriations to be administered by the U.S. Department of Health, Education, and Welfare. Doctor Teague said that the plan calls for providing information to rejectees on available medical, educational and rehabilitation services, which they will be encouraged to use.



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The award presented to the Kentucky Education Medical Political Action Committee by AMPAC at its annual Awards Dinner during the AMA Clinical Meeting in Miami in November, is shown by Henry B. Asman, M.D., Louisville, KMA secretary, who accepted the award on behalf of KEMPAC. The award is one of several presented to state medical political action committees who had rendered outstanding service to the political action movement during the year, and had demonstrated a high degree of political leadership.

Lexington Clinical Conference Apr. 1 Program Released

Program plans are now complete for the tenth annual Clinical Conference to be held April 1 at the Lexington Clinic under the auspices of the Kentucky Academy of General Practice and the Clinic.

Earl K. Shirey, M.D., a member of the staff of the Cleveland Clinic, Cleveland, Ohio, and Warren E. Wheeler, M.D., professor and chairman of the department of pediatrics at the University of Kentucky College of Medicine, will be the guest speakers for the day.

Doctor Shirey will discuss "Coronary Angiography" at the morning session, and Doctor Wheeler will speak on "Matching Bugs to Lesions of Infants" that afternoon.

Carroll L. Witten, M.D., Louisville, president-elect of the KAGP, will deliver the welcoming address at the start of the program. Other participants on the program are members of the Clinic staff.

Morning Program

"Acute Cardiac Problems" will be the topic of the morning session, presided over by Carl H. Fortune, M.D., Lexington. Papers being delivered during the session, and their authors, include: Myocardial Infarction—Allen L. Cornish, M.D.; "Complications of Anticoagulant Therapy"—James A. Orr, M.D.; "Heart Block"—M. Cary Blaydes, M.D.; and "Paroxysmal Tachycardia"—R. M. French, M.D.

Following a panel discussion on "Cardiovascular Emergencies" by Doctors Cornish, Orr, Blaydes, French and Richard D. Floyd, M.D., Doctor Shirey will speak.

A highlight of the program will be the talk by Francis M. Massie, M.D., on "The History of Transylvania Medical School", which will follow lunch at the Clinic.

Afternoon Session

John B. Selby, M.D., will moderate the first segment of the afternoon program, which is titled, "Genito-urinary Problems in Children." Guest speaker Doctor Wheeler will present his discussion at the beginning of the session, immediately followed by "Treatment of Urinary Infections in Children", by Erwin A. Jones, M.D., and "Vesico-uteral Reflux", by John R. Cole, M.D.

Moderator for the remainder of the session will be Eugene Todd, Jr., M.D. The following discussions will be presented: "Regional Anesthesia in Obstetrics"—Carl T. Evans, M.D.; "Treatment of ENT Problems in General Practice"—Robert M. Conlon, M.D.; and "Proctologic Problems"—Wilford L. Cooper, M.D.

The program, which adjourns at 4:30 p.m., is acceptable for five accredited hours by the American Academy of General Practice. For information and applications, write to The Lexington Clinic, 1221 South Broadway, Lexington, Ky. 40504.

Two Ky. M.D.s Named ACR Fellows

J. T. Ling, M.D., Louisville, and Robert D. Shepard, M.D., Lexington, were installed as fellows of the American College of Radiology at the ACR annual meeting in Philadelphia February 9-13.

Doctor Ling is professor and chairman of the department of radiology at the University of Louisville School of Medicine, and Doctor Shepard is assistant professor of clinical radiology at the University of Kentucky College of Medicine.

Yale Professor to Lecture

"Changing Clinical Aspects of Acute Rheumatic Fever" will be the topic of Alvan R. Feinstein, M.D., New Haven, Conn., 24th annual Samuel D. Gross Lecturer, who will appear April 21 at Rankin Ampitheater, Louisville General Hospital. The lecture is sponsored by Phi Chapter of Phi Delta Epsilon medical fraternity and the U. of L. School of Medicine. Doctor Feinstein, considered a world authority on rheumatic fever, is associate professor of medicine at Yale University School of Medicine. All physicians are cordially invited to attend.



Of 1,088 patients with confirmed skin and soft-tissue infections... 1,036 or 95.2% were treated successfully with Signemycin®

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Morador et al.* obtained *excellent results in the treatment of 185 out of 191 soft-tissue infections*, all due to staphylococci. They state: "In the most serious infections occurring in patients with impaired resistance (mainly diabetics) we have had very good results in the control of the infectious condition." In these studies, incision and drainage were employed where indicated.

*Morador, J. L. et al.: Antibiot. Ann. 1959-1960:716.

Condition	No. of Patients	No. Responded To Signemycin
Abscesses, various	35	34
Abscess, gluteal or perianal	54	52
Burns, infected	331	307
Carbuncles and furuncles	125	122
Cellulitis	104	102
Lacerations and wounds, infected	142	128
Ulcers, infected	107	106
Various superficial infections	190	185
Totals	1,088	1,036 (95.2%)

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Brief Summary and Bibliography follow.

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Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

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Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

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Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87]
In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Responded To Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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Kentucky Hospital Association To Meet Mar. 29-Apr. 1

Dr. Norman Vincent Peale, well-known lecturer and minister at Marble Collegiate Church, New York City, will be the featured speaker at the March 30 President's Luncheon during the annual meeting of the Kentucky Hospital Association at the Kentucky Hotel, Louisville, March 29-April 1 .

The President's Luncheon, at the Brown Hotel, will be one of the highlights of the meeting, which will include sessions on such topics as the Mandatory Nurse Practice Act and pharmacy legislation affecting hospitals, according to Ben R. Brewer, administrator of Western Baptist Hospital, Paducah, and president of KHA.

William H. McBeath, M.D., Frankfort, director of the Bureau of Medical Services for the Kentucky Department of Health, will participate in consulting services being offered on Wednesday afternoon, March 31. He will discuss the Kentucky medical care program.

Also appearing on the program will be Avil L. McKinney, director of Hospital-Physician service for Blue Cross Hospital Plans, Inc.; W. Leon Hisle, Berea, president-elect of KHA; Mrs. Nadine Turner, Murray, president of the Kentucky Nurses Association, and R. W. Leake, Jr., Danville, past president of the Kentucky Pharmaceutical Association.

Members of the Kentucky Medical Association are cordially invited to attend any or all of the scheduled convention activities, Mr. Brewer said.

ACOG Installs Four Ky. Fellows

Four Kentucky physicians will be installed as fellows of the American College of Obstetricians and Gynecologists at its annual meeting April 4-8 in San Francisco.

Charles J. Bohle, M.D., Paducah; Eugene A. Castle, M.D., Madisonville; Donald L. Ware, M.D., Louisville; and Donald E. Edger, M.D., Lexington, were listed as new fellows by the ACOG.

Pathology Board Certifies Two

Edward T. Arnn, M.D., and William L. Miller, M.D., both of Louisville, have been certified as diplomates of the American Board of Pathology, according to news recently released by the Intersociety Committee on Pathology Information. Doctor Miller is an instructor of pathology at the University of Louisville School of Medicine. Doctor Arnn is in private practice.

Second Health Center Opens

The second regional health center of the Kentucky State Department of Health opened February 15 at Hazard, State Health Commissioner Russell E. Teague, M.D., announced recently. Dillard Turner, M.D., London will be director of the center, which is to strengthen, support, and coordinate the work of 18 county health departments in the area.

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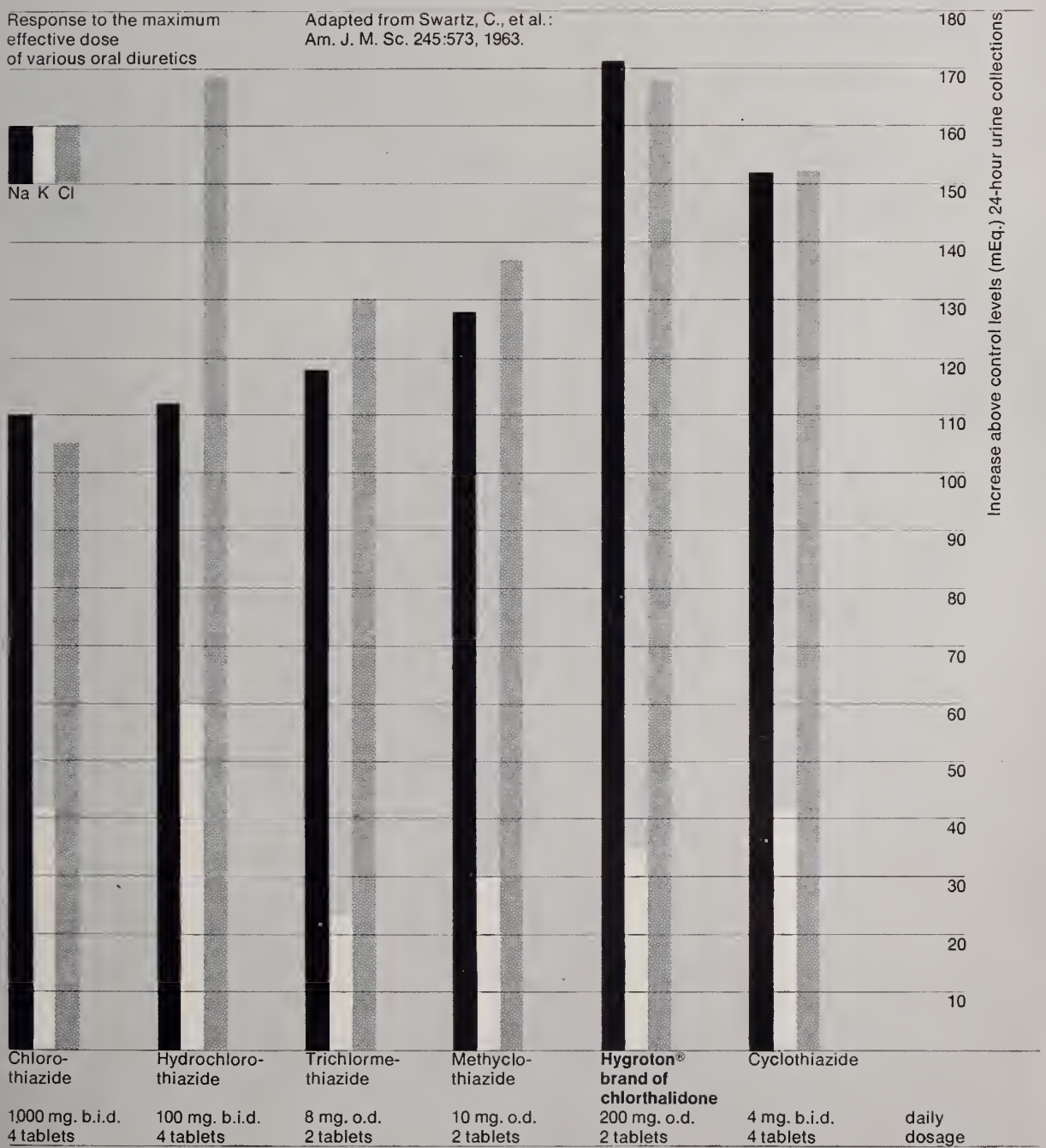
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Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity, and most cases of severe renal or hepatic disease.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, leukopenia, muscle cramps, nausea, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
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FOR SPACE IN THE SCIENTIFIC EXHIBIT

(Research and Teaching Exhibits)

1965 Annual Meeting — Kentucky Medical Association

Convention Center — **Louisville, Kentucky** — **September 21, 22, 23**

Fill Out and Mail to:

BENJAMIN B. JACKSON, M.D., Chairman

Committee on Scientific Exhibits

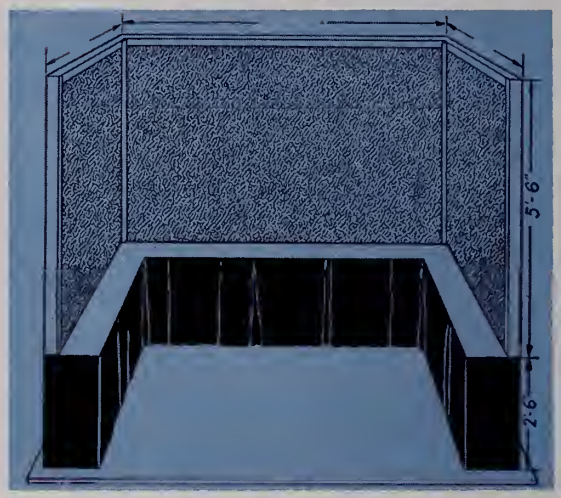
Kentucky Medical Association

3532 Janet Avenue

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1965

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit:
2. Name (s) of Exhibitor (s): (AMA Member?)

 Institution (if desired):

 Mailing Address
3. Do you have a built-in exhibit?
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)

 Charts and Posters.... Photographs.... Drawings X-rays....

 Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:

 Amount of wall space needed?

 Back wall Side walls (All side walls are 4')

 Square feet needed? Shelf desired? (yes or no)
7. Indicate sources of assistance provided in connection with the exhibit.
8. Has this exhibit been exhibited before? If so, when & where?

Date

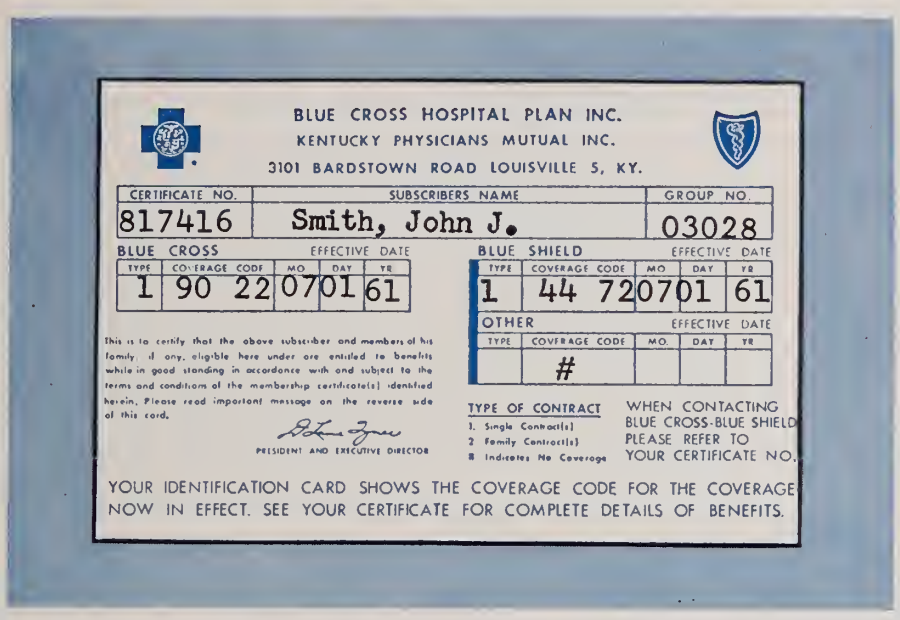
Signature of Applicant

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.



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Ky. Dental Association to Meet Apr. 4-7 in Louisville

Three Louisville physicians will be among the guest speakers at the 1965 annual meeting of the Kentucky Dental Association to be held April 4-7 at the Brown Hotel in Louisville, announced R. Burke Coomer, D.D.S., Louisville, KDA president, who released the meeting program.

Marion F. Beard, M.D., Ralph M. Denham, M.D., and George W. Pedigo, M.D., will take part in a panel discussion entitled, "Management of Dental Problems in Patients with Cardioviscular Disease" at the April 5 scientific session.

Maynard K. Hine, D.D.S., Indianapolis, president-elect of the American Dental Association, will be the featured speaker at a luncheon on Tuesday, April 6.

A luncheon honoring James F. Owen, D.D.S., who retired last summer as dental director of the Kentucky Department of Health, will be held on Monday, April 5. Donald J. Galagan, D.D.S., assistant Surgeon General of the U.S. Public Health Service, Washington, will be the main speaker.

Also appearing on the program will be Dean Raymond E. Myers of the University of Louisville School of Dentistry; Carl O. Boucher, D.D.S., a member of the dental school faculty at Ohio State University; Mr. Ferris Hoggard, Washington, of the U.S. Public Health Service; and Col. Charles Alling, of the Medical Research and Development Command, Washington.

Grant Given for Health Centers

A total of $104,000 in state funds was approved by Governor Edward T. Breathitt recently for help in construction of five new health centers and additions to two centers across the state. Counties where the new centers are located will provide additional money.

The five counties getting new centers are: Bullitt, Greenup, Letcher, Madison, and Trimble. Additions to existing health facilities will be built in Lee and Taylor Counties.

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1169 Eastern Parkway
Louisville, Kentucky
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News Items

John W. Scott, M.D., former KMA president, recently celebrated his 90.h birthday with a number of parties in his honor, including one entertaining the Fayette County Medical Society, given by his daughter and son, **Caroline Scott, M.D.**, and **Thornton Scott, M.D.**

Edward C. Frank, M.D., Louisville psychiatrist, has been appointed to the senior visiting faculty seminar at Harvard University. The seminar of 12 psychiatrists will study the theories of social psychiatry on grants from the National Institutes of Mental Health and the Grant Foundation.

Coleman C. Johnston, M.D., Lexington surgeon, recently was awarded the bronze medal for distinguished service in cancer control by the Kentucky Division of the American Cancer Society.

Robert M. Blake, M.D., has been named "Outstanding Young Man of the Year" in the Maysville area by the Maysville Junior Chamber of Commerce. Doctor Blake, a 1956 graduate of the University of Louisville School of Medicine, has been in practice in Maysville since 1959.

Glenn U. Dorroh, M.D., Lexington, has been elected president of the Fayette County Medical Society Foundation, which has recently been formed to promote and develop public health programs in Fayette County and Lexington.

Lowell E. Ford, M.D. has opened an office at Covington, where he will limit his practice to neurosurgery, it was recently announced. Doctor Ford, who recently completed his residency at Cincinnati General Hospital and affiliated hospitals, graduated in 1959 from Ohio State University School of Medicine, and interned at Christ Hospital, Cincinnati.

Edward C. Bowling, M.D. has opened an office at Stanford for the practice of general medicine and surgery. Doctor Bowling previously practiced at Lebanon for five years and in Florida for a short time.

Dominick E. Gentile, M.D., an internist, has joined the staff of Louisville General Hospital, it was recently announced. Doctor Gentile, whose main interest is nephrology, graduated in 1957 from Georgetown University School of Medicine in Washington, D.C., and interned in Detroit. Following his residency he was awarded a fellowship at Georgetown University to study renal disease.

Kenneth S. Welsh, M.D., who is currently on active duty with the U.S. Public Health Service, is serving with the Rowan County Board of Health with offices in Morehead. Doctor Welsh, on loan from the U.S.P.H.S. to the Kentucky Department of Health, is also a clinical instructor in community medicine at the University of Kentucky College of Medicine. He is a 1963 graduate of Western Reserve School of Medicine, Cleveland.

James E. McAfee, M.D., has started general practice at Horse Cave, where he will be associated with **K. M. Hill, Jr., M.D.** A September 1963 graduate of the University of Tennessee School of Medicine, Doctor McAfee interned at St. Joseph Hospital, Memphis. He is a native of Dyersburg, Tenn.

Dean H. Morrow, M.D., has joined the faculty of the University of Kentucky College of Medicine, department of anesthesiology. Doctor Morrow is a 1956 graduate of the Indiana University Shool of Medicine, and completed both his internship and residency at the I.U. Medical Center in Indianapolis. Before coming to Lexington he served with the U.S. Public Health Service.

Gerard A. Weigel, M.D., has started the practice of internal medicine at Somerset, where he is associated with **Elmer R. Smith, M.D.**, Doctor Weigel, who graduated in 1953 from St. Louis University School of Medicine, interned at affiliated hospitals of that school, and completed his residency at Henry Ford Hospital, Detroit.

Irene Elizabeth Roeckel, M.D., is a new member of the department of pathology at the University of Kentucky Medical Center. A native of Germany, she is a 1948 graduate of the University of Heidelberg. Doctor Roeckel interned at City Hospital of New York and Columbia University Hospital and was a resident at Emergency Hospital, Washington, D.C.

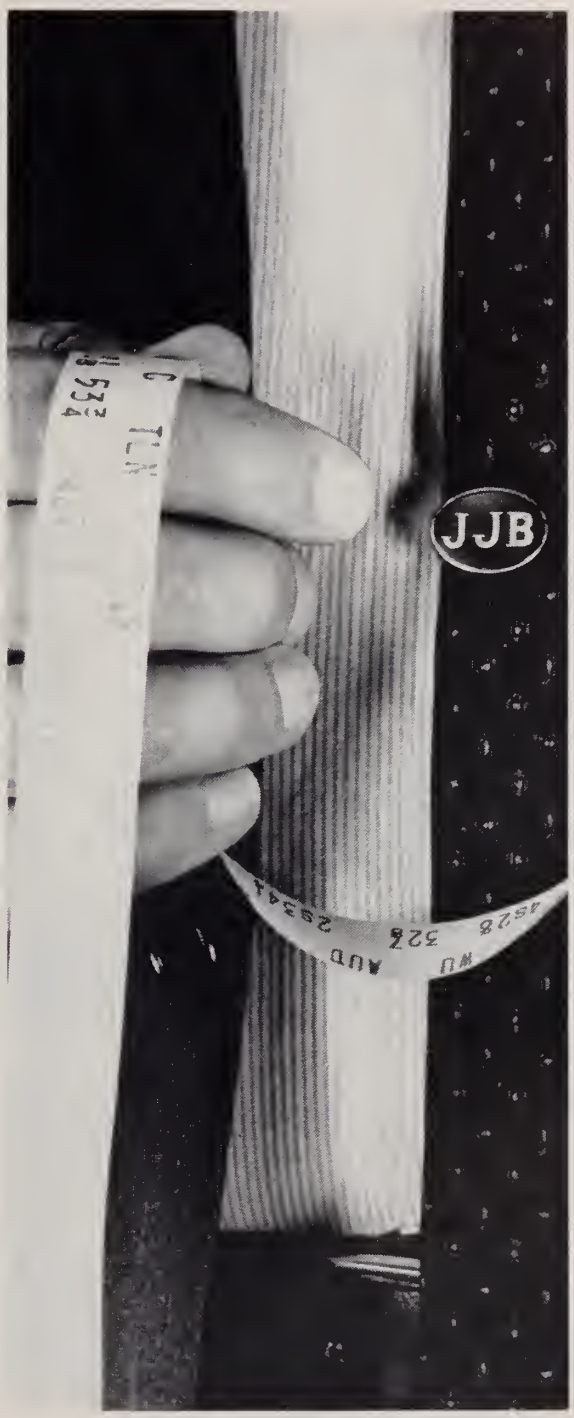
Larry L. Hall, M.D., has begun the practice of general medicine at Mayfield, where he is associated with the Fuller-Gilliam Clinic. A 1963 graduate of the University of Tennessee School of Medicine, he interned at Ball Memorial Hospital, Muncie, Ind.

S. H. Bowen, M.D., has started general practice in Harlan, it was recently announced. A 1946 graduate of the University of Louisville School of Medicine, he interned at St. Elizabeth Hospital in Covington. He previously practiced at Coeburn, Va., and Paintsville, Ky.

Warren T. Hill, M.D., has become associated with **C. H. Mathis, M.D.**, and **L. E. Johnson, M.D.**, at Russellville, where he will practice general medicine. Doctor Hill graduated in 1960 from the University of Tennessee School of Medicine and interned at Nashville General Hospital. Before entering the Air Force for two years, Doctor Hill practiced for several months at Portland, Tenn.

Charles W. Taylor, M.D., has opened an office at Lexington, where he will limit his practice to pediatrics. He was awarded his M.D. degree at Vanderbilt University in 1958 and interned at Vanderbilt Hospital. He completed his residency at Childrens Hospital in Cincinnati before serving for three years in the U.S. Army.

Romeo S. Berardi, M.D., has become associated with the Daniel Boone Clinic at McDowell. Doctor Berardi, a general surgeon, graduated in 1958 from medical school in Rome, Italty. After interning and serving part of his residency at Worchester City Hospital, Worchester, Mass., Doctor Berardi completed his residency at the V.A. Center in DesMoines, Ia.



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Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

MARCH

15	11th Annual KMA Senior Day, University of Louisville School of Medicine, General Hospital/Medical Arts Building, Louisville
17, 24, 31	Fourth Semiannual Postgraduate Course in "Psychiatry for Practicing Physicians," University of Louisville School of Medicine, course to be held at the Louisville Area Mental Health Center, 2:00-6:00 p.m., Louisville
18	KMA Interim Meeting, Gabe's, Owensboro
26	"Cardiology Night," Section of Cardiology, Department of Medicine, University of Kentucky Medical Center, 7:30-9:30 p.m., Lexington
19-Apr. 1	Kentucky Hospital Association Annual Meeting, Kentucky Hotel, Louisville
29-Apr. 2	Symposium on "Genito-Urinary Diseases," Radiology Department, University of Kentucky Medical Center, Lexington

APRIL

1-2	Kentucky OB-GYN Society Annual Meeting, Lexington
1	Lexington Clinic Conference, 8:30 a.m. to 4:30 p.m., Lexington Clinic, Lexington
3	"Professors Day," 9:00 a.m. to 3:00 p.m., University of Kentucky Medical Center, Lexington
4-7	Kentucky Dental Association Annual Meeting, Brown Hotel, Louisville
7	KAGP Lake Cumberland State Park Seminar, Jamestown
7, 14, 21, 28	Fourth Semiannual Postgraduate Course in "Psychiatry for Practicing Physicians," University of Louisville School of Medicine, course to be held at the Louisville Area Mental Health Center, 2:00-6:00 p.m., Louisville
8	Pediatrics, "Refresher Course," 8:00 a.m., to 5:00 p.m., University of Kentucky Medical Center, Lexington
9-10	Kentucky Chapter, American College of Surgeons Annual Meeting, Holiday Inn, Paducah
13	2nd Annual KMA Senior Day, University of Kentucky Medical Center, Lexington
15	University Surgery Day, 12:00 to 5:00 p.m., University of Kentucky Medical Center, Lexington
21	24th Annual Samuel D. Gross Lecture, 12:00 Noon, Rankin Amphitheater, Louisville General Hospital, sponsored by Phi Delta Epsilon and University of Louisville School of Medicine
22-23	Kentucky Thoracic Society, University of Kentucky Medical Center, Lexington
30	"Cardiology Night," Section of Cardiology, Department of Medicine, University of Kentucky Medical Center, 7:30-9:30 p.m., Lexington

IN SURROUNDING STATES

MARCH

15-19	American College of Physicians, Postgraduate Course No. 11, Emory University School of Medicine, Atlanta
17-18	Postgraduate Course, "Advances in Urology," Cleveland Clinic, Cleveland, Ohio
19-21	American Society of Internal Medicine, Conrad Hilton Hotel, Chicago
22-26	American College of Physicians (Golden Anniversary Session), Chicago
24	Seventh Annual "Resident's Day," in OB-GYN, Wayne State University, Wayne County Medical Society Building, 1010 Antietam Street, Detroit
26-27	American Medical Association Council on Rural Health—18th National Conference on Rural Health, Americana Hotel, Miami Beach
29-31	American Association for Thoracic Surgery, Roosevelt Hotel, New Orleans
29-Apr. 1	Southeastern Surgical Congress, Statler Hilton Hotel, Washington, D. C.
29-Apr. 10	Course in Laryngology and Bronchoesphagology, University of Illinois Medical Center, Chicago
31-Apr. 2	Symposium on "Gastroenterology," Medical College of Georgia, Augusta



Attention Physicians!

YOU ARE INVITED TO ATTEND



Scientific Session Of The Kentucky Thoracic Society

APRIL 22, 1965

University of Kentucky Medical Center

PROGRAM

Morning Session
9 a.m. to 12 noon

"The Future of TB Control"

Joseph B. Stocklen, M.D., Medical Supt. and Controller of Chronic Illness and TB, Cuyahoga County TB Hospital, Cleveland, Ohio

"Cross Reactions of Atypical Bacteria"

George W. Comstock, M.D., Consultant, TB Branch Communicable Disease Center, United States Public Health Service; Associate Professor of Epidemiology, Johns Hopkins University, Baltimore, Maryland

"Fungus Diseases of The Lungs"

Michael L. Furcolow, M.D., Professor of Epidemiology, University of Kentucky College of Medicine, Lexington, Kentucky

Reactor:

M. Stuart Lauder, M.D., Director, Division of TB Control, Kentucky State Department of Health Frankfort, Kentucky

Afternoon Session
2 — 5 p.m.

"The Immunology of Respiratory Diseases of The Lungs"

Tom D. Y. Chin, M.D., Chief, Kansas City Field Station Department of Health, Education and Welfare, Kansas City, Kansas

"Clinical Aspects of Respiratory Allergy"

Leon Unger, M.D., Emeritus Associate Professor, Northwestern University School of Medicine; Senior Physician, Chicago Wesley & Memorial Hospitals Chicago, Illinois

"Immunological Specificity of Respiratory Mucosa"

Noel R. Rose, M.D., Ph.D., Associate Professor, Bacteriology and Immunology, School of Medicine, State University of New York, Buffalo, New York

KMA Council and Committee Reports

Council on Medical Education and Hospitals

George Sehlinger, M.D., Louisville, Chairman

KMA Headquarters Office **January 21, 1965**

This KMA Council on Medical Education and Hospitals held their initial meeting for this associational year and received the reports from the chairmen of the various committees serving under the Council. Members of the Council reviewed an interim report on the evaluation of the questionnaire on medical education and also reviewed actions taken by the AMA House of Delegates in December, 1964, that were of interest to the Council.

The Council members heard a final report on the Kentucky Medical Association postgraduate office and recommended to the Board of Trustees that the monies in the postgraduate education fund be returned to the Kentucky Medical Association general fund account and that the Kentucky Medical Association membership be informed of this action.

It was announced at the meeting that the AMA Council on Medical Education would meet in Louisville on March 12 and 13. The next meeting of the KMA Council was scheduled for May 13.

The Hospital Committee

James Holloway, M.D., Lexington, Chairman

KMA Headquarters Office **February 11, 1965**

The KMA Hospital Committee hosted representatives of the Kentucky Medical Association and Kentucky Association of Registered Medical Librarians at their meeting and a thorough discussion was held on the problems associated with emergency rooms and medical records. The committee requested authorization from the Board of Trustees to work with the Hospital Association in producing a booklet on "Uses of Emergency Room" for distribution.

Area Wide Hospital Planning on a voluntary basis was also considered by the committee and a recommendation was read to the Board that KMA take the lead in initiating a state wide group for this purpose.

Among other matters discussed were referrals from the KMA Executive Committee and actions of the AMA House of Delegates. The Committee will meet again on May 20.

Council on Legislative Activities

John C. Quertermous, M.D., Murray, Chairman, National Affairs

James C. Cantrill, M.D., Georgetown, Chairman, State Affairs

Louisville **January 13, 1965**

The Council on Legislative Activities met at the KMA Headquarters Office with the district key men invited as guests. AMA's field representative for Kentucky, Mr. Harry Hinton, was also in attendance.

Reports were given by the KMA representative to the AMA Education Conference and the Kerr-Mills Conference held in Chicago on January 9-10. It was at this Conference on January 9 where Donovan F. Ward, M.D., president of the AMA, gave his statement regarding AMA's proposed health care program. The plans for the 1965 Congressional Dinner were made for February 16 in Washington, D. C. The program to be presented by the Council at the Interim Meeting to be held in Owensboro on March 18 was finalized. Reports were given on a proposed Nurses' Bill, the Sub-Committee to Study Cults, and the present Coroners System.

Committee on Disaster Medical Care

William T. Rumage, Jr., M.D., Louisville, Chairman

KMA Headquarters Office **January 14, 1965**

A number of guests representing allied organizations attended the KMA Disaster Medical Care Committee Meeting and heard the latest reports on packaged emergency hospitals located in Kentucky. A report was also presented on the number of persons that have completed the Medical Self-Help Course in Kentucky. The development of city disaster plans was urged by the Committee members.

A discussion was held on the Governor's Emergency Research Planning Health Task Force on which this committee is represented and a report of a recent meeting of the Task Force was presented.

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Highway Safety Committee

John J. Robbins, M.D., Louisville, Chairman

Louisville **January 28, 1965**

In this, its first meeting of the new year, the Highway Safety Committee reviewed its purposes at the beginning of the meeting. Arthur H. Keeney, M.D., the Committee's past chairman, reported on the committee's activities for 1964 and its report to the House of Delegates.

The primary discussion and action of the committee centered around the final six-month phase of the Automotive Crash Injury Research Program conducted by Cornell University, the Kentucky Driver Limitation Program, Compulsory Annual Automobile Inspection, and additional promotion of the 100 Per Cent Seat Belt Award program.

The Executive Committee Rural Kentucky Medical Scholarship Fund

C. C. Howard, M.D., Glasgow, Chairman

Louisville **January 27, 1965**

The Executive Committee of the Scholarship Fund had Mr. George D. Caldwell of The Louisville Trust Company, which is the fiscal agent for the Fund, review the financial status of the fund. A report was given of the number of new loans made and the number of second, third and fourth loans made during 1964. The Postgraduate Committee gave its report and recommended certain residencies to be authorized. They further recommended that the Postgraduate Committee be given permission to encourage more residencies in internal medicine and pediatrics.

The Committee reviewed the situation pertaining to the ten "critical counties." The Chairman outlined a new program that was approved with the hopes that it would encourage more young physicians to locate in these counties. This program is developed to help the young physician starting practice now as well as a medical student who agrees to practice in a critical county after completing his training.

Special KMA Committee to Study Medical Practices in the ARHI

Douglas E. Scott, M. D., Lexington, Chairman

Imperial House, Lexington **February 3, 1965**

Medical practices in the Appalachian Regional Hospitals were discussed at a recent meeting by a special committee appointed by the Board of Trustees. The committee members, meeting for the fourth time since their appointment, also reviewed the three statements approved by the Kentucky Medical Association in April 1963 pertaining to the Appalachian Regional Hospitals and discussed the extent of implementation of these principles.

The committee members periodically meet with the director of the ARHI to exchange information on various aspects of the transition of these hospitals to community hospitals.

In Memoriam

ROBERT WILLIAMS HAHS, M.D.
Murray, Ky.
1913-1965

Robert W. Hahs, M.D., Murray pediatrician, died January 28 at his home following an illness of several years. Doctor Hahs, who retired in 1962 because of ill health, graduated in 1939 from the University of Louisville School of Medicine. After serving for four years in the Medical Corps of the U.S. Army in World War II, he was discharged in 1946 with the rank of lieutenant colonel.

EDWARD WHITE FORD, M.D.
(Formerly) Fordsville, Ky.
1867 - 1954

Edward White Ford, M.D., 97, a native of Ohio County and a former general practitioner there, died at his home at Crescent City, Fla., after a brief illness. Doctor Ford, who graduated in 1891 from Jefferson Medical College, Philadelphia, practiced in Fordsville and Ohio County for several years before moving to Florida in 1919. He had been retired for many years.

MAHLON M. HARLAN, M.D.
(Formerly) Mayfield, Ky.
1923 - 1964

Mahlon M. Harlan, M.D., 41, former anesthesiologist at Fuller-Morgan Hospital in Mayfield, died November 15 at his home at Los Angeles following a heart attack. Doctor Harlan, a 1950 graduate of the Southwestern Tennessee College of Medicine in Memphis, practiced in his home town of Barlow for a time before going to Mayfield. He moved to California ten years ago.



POST-GRADUATE SEMINAR

IN

DIAGNOSIS AND TREATMENT

OF

RHEUMATOID ARTHRITIS

SPONSORED BY THE KENTUCKY ARTHRITIS FOUNDATION
AND THE UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE

Louisville General Hospital **APRIL 15, 1965** Rankin Amphitheater

This seminar will be concerned with new advances in diagnosis and treatment of rheumatoid arthritis. The morning session devoted to diagnosis and related aspects, and the afternoon session to management. Each session will conclude with panel discussion and audience participation. Nationally-known visiting faculty in attendance.

GUEST SPEAKERS:

Thomas Brower, M.D.
Lexington, Ky.

Jerome Rotstein, M.D.
New York, N.Y.

Joseph E. Levinson, M.D.
Cincinnati, Ohio

Otto Steinbrocker, M.D.
New York, N.Y.

Jack Zuckner, M.D.
St. Louis, Mo.

Norman Rothermich, M.D.
Columbus, Ohio

Morris Ziff, M.D.
Dallas, Texas

GUEST PANELISTS:

Evelyn Hess, M.D.
Cincinnati, Ohio

Joseph Warren, M.D.
Lexington, Ky.

FACULTY, U. OF L.:

David H. Neustadt, M.D.
Louisville, Ky.

William P. Peak, M.D.
Louisville, Kentucky

Beverly T. Towery, M.D.
Louisville, Ky.

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Dosage: Adults—250 mg. every six hours in respiratory infections; 500 mg. every six hours in urinary and gastrointestinal infections (higher doses may be needed in severe infections). Children—(under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours; 200 mg./Kg./day in divided doses every six hours for severe infections.

Contraindications: (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms. *Aerobacter aerogenes*, *Pseudomonas pyocyanea*, and *Proteus morganii* are resistant to PENBRITIN (ampicillin).

Side Effects: Mild effects, such as skin rashes, diarrhea, nausea and vomiting have occasionally appeared.

Precautions: As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

Supplied: No. 606—Each capsule contains 250 mg. of ampicillin. Bottles of 16 and 100.

References: 1. Rolinson, G. N., and Stevens, S.: Brit. M. J. *ii*:191 (July 22) 1961. 2. Editorial. Lancet *ii*:723 (Oct. 5) 1963. 3. Parker, M. T., *et al.*: Brit. M. J. *i*:1550, 1962. 4. Evans, W., and Hansman, D.: Lancet *i*:451 (Feb. 23) 1963. 5. Richards, J. D. M., and Ryeroft, J. A.: Lancet *i*:553 (March 9) 1963. 6. Schaedler, R. W., *et al.*: New England J. Med. *270*:127 (Jan. 16) 1964. 7. Howard, P., and Riley, H. D., Jr.: Abstracts, Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, Oct. 26-28, 1964, New York, N.Y.

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Rheumatic Disease Seminar Set

Rheumatic Diseases will be the topic of a postgraduate seminar on April 15 at Rankin Amphitheater, Louisville General Hospital, sponsored by the Kentucky Arthritis Foundation and the University of Louisville School of Medicine.

The Seminar, acceptable for continuation study credit by the American Academy of General Practice, features a visiting faculty of nationally known investigators who will discuss recent advances in diagnosis and treatment of rheumatoid arthritis. For further information, see the advertisement on page 220 of this issue.

Pertinent Paragraphs

The American Industrial Health Conference, a combined meeting of the Industrial Medical Association and the American Association of Industrial Nurses, will be held April 5-8, according to John F. Shronts, M.D., Minneapolis, general chairman of the Conference. The meeting will be at the Americana Hotel in Bal Harbour, Fla.

Sidney Nelson, M.D., professor and chairman of the department of Radiology at Ohio State University School of Medicine, will deliver the 17th annual Joseph and Samuel Freedman Lectures in Diagnostic Radiology at the University of Cincinnati College of Medicine April 24 and 25. Radiologists interested in the seminar are requested to write to Banjamin Felson, M.D., Dept. of Radiology, Cincinnati General Hospital, Cincinnati, O., 45229.

Gill Memorial Eye, Ear, and Throat Hospital, Roanoke, Va., has announced completion of program plans for the 38th Annual Spring Congress in Ophthalmology April 5-8 in Roanoke. For information write to: Superintendent, Box 1789, Roanoke, Va.

Good Samaritan Hospital in Cincinnati has announced its third annual Seminar on Premature Care to be held April 15 from 1:00 to 6:00 p.m. Guest Speakers will include Gerard B. Odell, M.D., Johns Hopkins Hospital, Baltimore; Virginia Apgar, M.D., The National Foundation, New York City; and Henry C. Cramblett, M.D., Ohio State University, Columbus. Physicians wishing to attend should contact James J. Englert, M.D., Chairman, Premature Seminar, Good Samaritan Hospital, Cincinnati, O., for reservations.

"Diseases of the Nervous system: Clinical and Pathological Considerations", will be the subject of a one-day seminar April 3 in St. Louis, sponsored by the Missouri Society of Pathologists. For information contact: James G. Bridgens, M.D., Secretary, Missouri Society of Pathologists, St. Joseph's Hospital, Linwood at Prospect, Kansas City, Mo., 64108.

Some 250,000 Kentucky veterans of World War II and the Korean Conflict may be eligible to purchase new insurance under the provisions of recently enacted legislation reopening the GI insurance program. Interested veterans may obtain information sheets by writing or telephoning the VA Regional Office, 1405 West Broadway, Louisville, Ky., 40203, telephone 582-5811.

Pamphlets on birth defects are now available from the National Foundation-March of Dimes. These are reprints of articles which have appeared in scientific and medical literature published in the United States and abroad. For a list of titles and other information, write to: Medical Department, The National Foundation-March of Dimes, 800 Second Avenue, New York, N.Y., 10017.

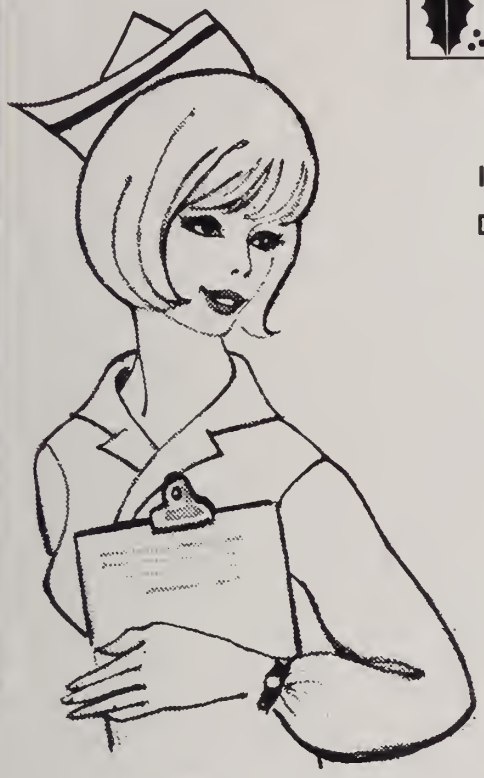
The American Society for the Study of Sterility will hold its 21st annual meeting at the Jack Tar Hotel in San Francisco April 2-4. For information write to William H. Robertson, M.D., 2700 Tenth Avenue South, Birmingham, Ala., 35205.

The Ninth Postgraduate Course in Trauma will be presented April 28-May 1 at the John B. Murphy Memorial Auditorium, Chicago, by the Chicago Committee on Trauma of the American College of Surgeons. The course is acceptable for 31½ hours Category II credit by the American Academy of General Practice. For information write to: John J. Fahey, M.D., 1791 Howard Street, Chicago, Ill., 60626.

The 31st Annual Meeting of the American College of Chest Physicians will be held June 17-21 at the Waldorf-Astoria Hotel in New York City. June 21 has been set aside for a combined meeting of the ACCP with the Section on Diseases of the Chest of the American Medical Association.

"Summa Medica", a systematic, sequential curriculum of lectures by medical authorities, issued weekly on magnetic tape, is now available to Kentucky physicians. Lectures are presented in categories such as gastroenterology, anesthesiology, cardiology, orthopedics, and many others. For additional information, contact Lifelong Medical Learning, Inc., 1832 East Michigan Avenue, Los Angeles, Calif., 90033.

The purpose of drug investigation is to acquire and interpret reliable data which may either lead to practical medical conclusions about new therapeutic agents, or bring about a better understanding of the body systems and the ways in which disease affects them. The object is not to placate or please, to avoid controversy, or shun possible lawsuits, but to gain knowledge in the interest of mankind. Acquistion of new knowledge, the finding of new cures, and the solving of some of the more stubborn mysteries in the health field, are what motivate the drug researcher.—Austin Smith, M.D., in *Experimental Medicine and Surgery*, 22: 2-3, (June/Sept.) 1964.



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Temporary Tube Gastrostomy

(Continued from Page 173)

days and the other a week. No fatalities related to the gastrostomy occurred in this series of patients.

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Arteriosclerotic Gangrene

(Continued from Page 177)

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Public Health Page

(Continued from Page 162)

(9) This new testing program is available to the same group of medically indigent prenatal patients as in the past under the old Rh program, and to patients who may not otherwise have this service available to them in their local area.

The success of this program will depend upon a full understanding of this program and the services available, both on the part of the local physicians and the local health departments.

* * *

Recently a major American pharmaceutical firm was successful in suing a former employee for selling secrets of research and production of an antibiotic to an Italian drug manufacturer—however, not until long after the Italian firm, whose research and development costs had thus been paid by the American competitor, had underbid the same firm in a large sale of this drug back to the United States government . . . Vigorous protests by many persons and organizations are now being made against purchases by our government of foreign drugs produced on the basis of formulae and methods stolen from ethical American manufacturers.—Editorial, in *Rocky Mountain Medical Journal,* 61: 10, (Oct.) 1964.

It is worth noting that the law . . . (now) requires the investigators of new drugs to inform "any persons used as controls" that *"drugs* are being used for investigational purposes." The term "drugs" is confusing because it could refer to the new drug itself or to placebos or standard drugs given to the controls. Disclosure of full information to the controls may be highly detrimental to the drug study. Such disclosure introduces a highly undesirable psychologic element, inconsistent with the statutory requirement for adequate and well controlled studies for proving the effectiveness of a new drug. The conclusion is inescapable. The federal regulations and, if need be, the law, should be modified, so as not to interfere with medical practice and the orderly investigation of new drugs.—Francis Boyer, Chairman of the Board, Smith Kline and French Laboratories, in *New England Journal of Medicine,* 270: 15, (April 9,) 1964.

It is possible that some of the disagreement concerning the place of clinical pharmacology in the departmental structures and curriculums of medical schools results from a lack of separation of the teaching of therapeutics from the teaching of research technics in the evaluation of the effects of drugs. In the former instance it is clear that the physician trained in a specialty is best able to teach students and other physicians about his own field. But that physician may not be interested in teaching, especially by example, the principles of the good therapeutic trial. Yet the students must be aught these principles if they are to evaluate properly the therapeutic literature, and they certainly must gain some experience with the problems if they are to conduct research in therapeutics on their own.—Thomas C. Chalmers, M.D. in *New England Journal of Medicine,* 270:3 (Jan. 16) 1964.

Francis Boyer, chairman of the board of Smith Kline and French Laboratories, in a special article . . . indicates additional hazards associated with the clinical testing of new drugs as a result of the 1962 amendments to the previously existing food and drug legislation. Not only is the physician thus engaged subjected to a greatly increased burden of paper work, but also to the so far unpredictable possibility of legal action, since the FDA certificate that he is required to submit states that his patients are being used for the purpose of investigating new drugs, with no indication that they may be benefited thereby. Certainly, a tangled web seems to have woven in the effort to ensure that all drugs reaching the market are both reasonably safe and reasonably effective.—Editorial in *New England Journal of Medicine,* 270: 15, (April 9,) 1964.



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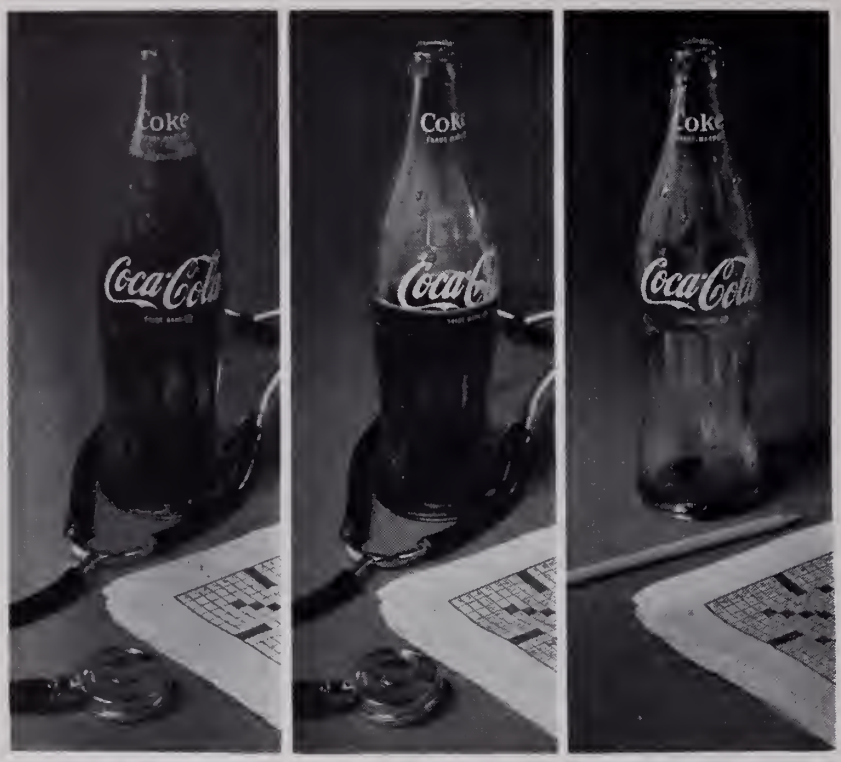
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COMMON BACTERIAL INFECTIONS—Pathophysiology and Clinical Management: by Edwin J. Pulaski, Col., M.C., U.S. Army; published by W. B. Saunders Co., Philadelphia, 1964; 301 pages; price, $8.50.

In the preface to this book the author indicates that he was motivated by a genuine desire to write a book dealing with the complex and rapidly growing fields of infectious diseases and antimicrobial therapy designed to be used as a source of continuing education for the busy practitioner. Colonel Pulaski draws heavily from his extensive surgical experience and from the vast store of visual aids and photographs from Walter Reed Army Institute of Research and the Armed Forces Institute of Pathology. In this reviewer's opinion the author has achieved this goal.

The first two chapters are devoted to brief reviews of the dynamics of infectious disease and the currently accepted concepts of antimicrobial therapy. Following this the remaining nine chapters discuss infections of various anatomic systems or infections associated with trauma, burns and the abdominal structures. These divisions appear to be logical and in general, are written more from the view point of the surgeon rather than the internist or general practitioner. In this light the book can be described as adequate.

The major objections to this book are: 1) that it doesn't live up to its title and 2) the author's style of writing in which he says one thing but obviously means something else. The first of these objections can be substantiated by reading the table of contents and the index. It becomes immediately apparent that this book dealing with "Common Bacterial Infections" makes no mention of gonorrhea, syphilis, and the other venereal diseases. This is most unusual when one considers that the author has spent most of his professional career in the Army Medical Corp and could write most authoritatively on venereal diseases. There are other notable and important omissions. No mention is made of meningococcemia, listeric infections, and leptospiral infections, to mention a few.

The discrepancy in the author's style of writing is in evidence on the very first page where this statement is made: "Pathogens are those microbes which evoke an abnormal response in the host." Obviously the author didn't mean this because the host would surely be in trouble if his response was not a normal one.

Another example of mistaken meaning can be found on page 23 where the author writes of "basic principles of anti-infective therapy" . . . Obviously the author was referring to antimicrobial therapy and he should have said so. An example of confusing statements is found on page 28 where the author writes "Pneumonia may be caused by any of five species of bacteria . . ." then on page 200 the author lists as causes of bacterial pneumonia five distinct bacterial species plus four other large groups of bacteria. This amounts to considerably more than five species.

While perhaps of minor significance to the intended reader, the book contains several rather serious errors in basic bacteriology. Space permits mentioning just a few. On page 272 the following statement is made: "The *E. coli* group is relatively non-mutagenic." This statement is a distinct contradiction to virtually every concept of microbial genetics because the *E. coli* group has been and still is one of the most frequently selected groups of organisms for genetic research due to its remarkable mutagenic ability. On page 273 it is stated that *Proteus mirabilis* is able to produce indole and that *Pseudomonas aeruginosa* is often a urea-spliter. Both of these stated biochemical abilities are wrong.

Each chapter is followed by what appears to be an adequate bibliography but generally there are no specific references in the text to the bibliography making it rather difficult to obtain more information from the scientific literature to which the author refers.

In this reviewer's opinion this book needs a thorough and extensive editing job. Then it may well deserve a place on the physicians bookshelf.

ALBERT BALOWS, PH.D.

PHYSICAL EXAMINATION OF THE SURGICAL PATIENT, Third Edition: By J. Englebert Dunphy, M.D., and Thomas W. Botsford, M.D.; Published by W. B. Saunders Co., Philadelphia, 1964; 396 pages; price, $8.50.

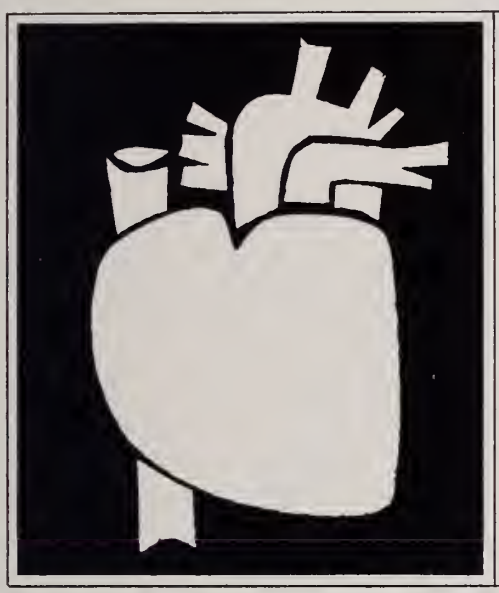
This volume was first issued in 1953 "to focus attention on the methods and importance of eliciting physical signs in surgical conditions". It was welcomed as a ready source for concise information on those portions of the physical examination of particular interest to surgeons in contrast to the major emphasis upon the thorax in traditional texts on physical diagnosis.

Widespread acceptance of this manual necessitated a second edition which appeared in 1958. The third edition, here reviewed, continues the high standard set in previous volumes. The authors point out that since the first edition there has been a complete change in the surgical approach to heart disease, and trauma has become increasingly common as a basis for hospital admission. Thus, new chapters on cardiac surgery, on burns and on emergency resuscitation appear in this revision.

This is an extremely useful small volume which should continue to be of great value not only to medical students and house officers but also to the practicing surgeon who wishes to refresh his memory relative to "the tools: eyes, ears, fingers, nose and brain" in the diagnosis and treatment of the surgical patient.

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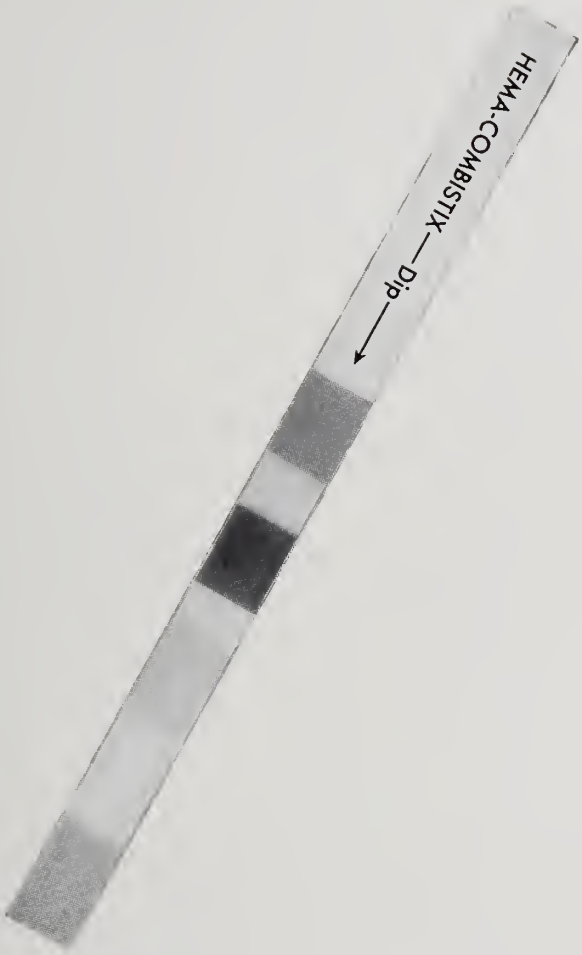
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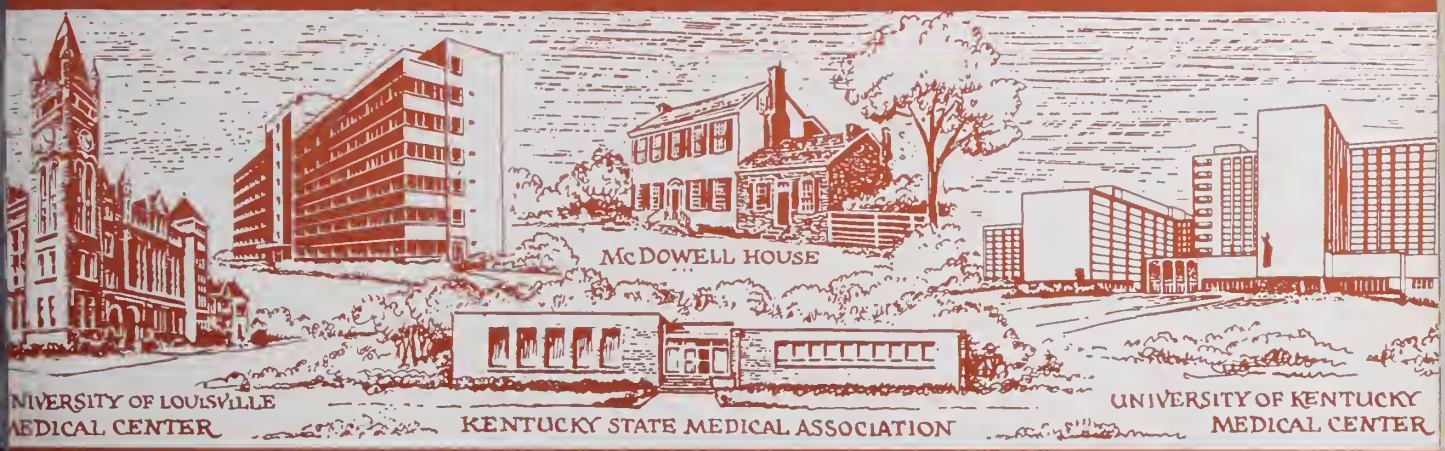
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OF THE KENTUCKY MEDICAL ASSOCIATION



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*Lennox, W. G.: Epilepsy and Related Disorders, Boston, Little, Brown and Company, 1960, vol. 2, p. 865.

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Kentucky Blue Cross in 1964 paid to hospitals the sum of $27,308,211.00 for services rendered their members. Such payments over the years have no doubt been responsible for a major part of the successful operation of Kentucky hospitals as private institutions. Kentucky Blue Shield paid to physicians in 1964 the sum of $9,469,136 for services rendered members that otherwise may never have been paid.

The successful operation of these Plans in providing for the needs of people is a bulwark against encroachment by government into the free enterprize system.

Let us as physicians help people *properly* use their benefits. Unnecessary hospitalization, extended lengths of stay and improper use of ancillary services create waste of the health care dollar, and would eventually destroy the Voluntary System.

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Usual dosage: Adults – 250 mg. every six hours in respiratory infections; 500 mg. every six hours in urinary and gastrointestinal infections (higher doses may be needed in severe infections). Children – (under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours for moderately severe infections; 200 mg./Kg./day in divided doses every six hours for severe infections.

Contraindications: (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms.

Side Effects: Mild effects, such as skin rashes, diarrhea, nausea and vomiting have occasionally appeared.

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THE INSURANCE PAGE



Hospital Costs

THE single most apparent and most important thing about hospital bills today is that they are high, and are rising, and give every indication that they will continue to rise. This, plus the fact that more people are being admitted, and more services are being ordered per patient, points toward a continuing cost crisis in pre-payment hospital insurance.

Hospitals are engaged in a variety of important efforts to make their dollars go further. Experts are introducing many interesting new practices and administrative innovations calculated to conserve community health dollars. Some of these programs are hardly above the experimental level, but many others have been amply field-tested by now, and hold great promise of whittling away at rising costs.

Experts in the field of hospital costs fully appreciate the two basic reasons why hospital care today must cost more than it did a decade or even five years ago.

They recognize that: 1, Higher costs must attend technical advances in medicine and surgery. 2, Hospital workers should receive decent wages. We can't turn back the clock here—nor would we wish to.

But additional factors generally viewed as contributing to the growing bulge of the patient's hospital bill can and should be managed. Briefly, these are: 3, Unnecessary hospital admissions. 4, Faulty, inefficient use of hospital services or days of stay due to poor scheduling or weak handling of the individual case because of adherence to outmoded "system". 5, Ineffective employment and deployment of the hospital's army of unskilled help. Too often this is responsible for the rising ratio of personnel to patients. "Let's hire a half dozen more" is not always the answer. ("Let's better train and use the people we have" makes more sense in cutting down expensive turnover.) 6, Unnecessary hospital construction and inter-institutional rivalry that results in duplication of services in the community.

Doctors have a responsibility to take an active interest in methods by which they can contribute to hospital cost reductions. The preservation of the best medical care in the world is basic to our way of life. Continuing it in an age when, increasingly, strident voices are heard urging government intervention, is a responsibility resting heavily on the hospital trustee and the hospital administrator, as well as the doctor.

Success can only be achieved when the highest quality of hospital care is provided at the lowest possible cost.

WILLIAM W. HALL, M.D.



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The initial response is usually maintained without dosage increases; indeed, initial dosage is often reduced for maintenance purposes.

Salicylate or steroid therapy can usually be diminished or, in some instances, eliminated.

Psoriatic arthritis responds in the same way as rheumatoid arthritis but the skin lesions are usually not affected either favorably or adversely by treatment.

Precautions
Before prescribing, the physician should obtain a complete history and perform a complete physical and laboratory examination, including a blood count.

The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools.

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Side effects
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug.

Contraindications
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when other potent chemotherapeutic agents are given concurrently because of the increased possibility of toxic reactions; when the patient cannot be seen regularly; when the patient is senile.

Note: The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

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Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

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Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

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PEDIATRIC PROCEDURES: by Walter T. Hughes, M.D.; Published by W. B. Saunders Company, Philadelphia, 1964; 208 pages; price, $7.50.

Doctor Hughes has successfully organized diagnostic and therapeutic procedures into an easy to read and understand textbook of 200 pages. A thorough scan of the literature, his personal experiences, and those of others give the book an authoritative flavor. He describes each technique with clear detail, discussing necessary equipment and common pitfalls encountered.

There are 14 chapters with many excellent illustrations and references. The chapters concerning preparation of the patient, measurements, and injections, are "just what the doctor ordered." The practicing physician will find these chapters an aid in training his hospital and office employees how they can best help him.

Specific chapters are devoted to blood collection, infusions, bone marrow aspiration and exchange transfusions. Hughes mentions pre-packed disposable exchange transfusion sets. These sets make exchange transfusion possible wherever there is an adequate blood bank and a physician who recognizes when an exchange is indicated.

The remaining seven chapters divide the procedures as they pertain to the major body-organ systems. Typical procedures such as lumbar puncture, subdural puncture, pneumoencephalogram, removal of foreign bodies from ear and nose, artificial respiration and mechanical ventilation, laryngoscopy, tracheostomy, thorocentesis, gastrointestinal intubation, percutaneous liver biopsy, paracentesis, cardiac massage, periocardiocentesis, urine collection and catheterization, circumcision, bandaging, and sweat chloride collection are described. Highly specialized procedures as renal biopsy, cardiac catheterization, peritoneal dialysis, and broncoscopy are purposely omitted.

Interns and residents learn most of these procedures by the "see one—do one" method. They can now read one—see one—do one. All physicians responsible for the care and treatment of children will find many helpful hints readily available in this book.

GARNER E. ROBINSON, M.D.

SCINTILLATION SCANNING IN CLINICAL MEDICINE: Edited by J. . Quinn, III, M.D.; Published by W. B. Saunders Co., Philadelphia, 1964; 278 pages; price, $11.50

This book is a collection of papers presented at a symposium on scintillation scanning held at the Bowman Gray School of Medicine in January, 1964.

Beginning with chapters on the fundamental physical aspects of scintillation scanning and the pharmacological principles involved in the use of radiopharmaceuticals the book continues with chapters covering scanning of all organs and tissues which are currently being done. Indications, limitations, apparatus and methodology are all discussed in considerable detail. The book is profusely illustrated. A final chapter is devoted to the development and future of scintillation scanning.

The contributors are well known in the field of nuclear medicine. The book should be a helpful reference for all who are interested in this rapidly expanding and changing field.

RALPH M. SCOTT, M.D.

POLYPOID LESIONS OF THE GASTROINTESTINAL TRACT: By Claude E. Welch, M.D.; Published by W. B. Saunders Co., Philadelphia, 1964; 148 pages; price, $7.50.

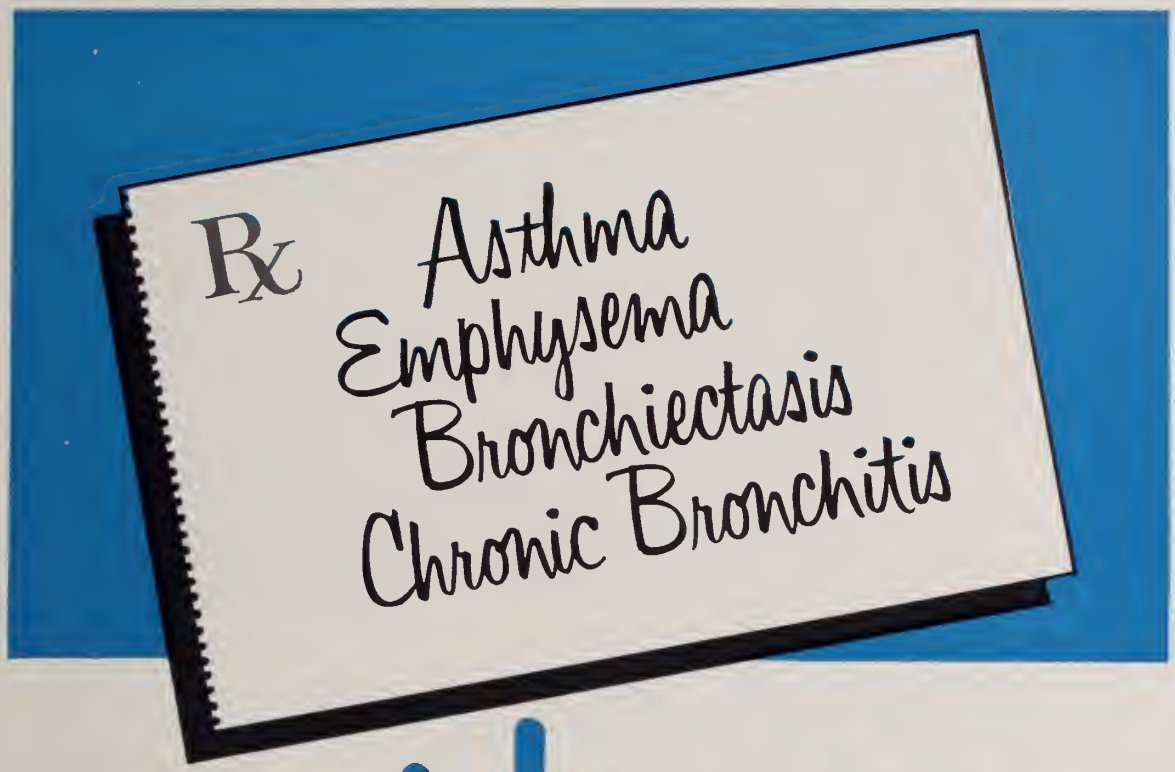
This monograph by one of the leaders in American surgery will furnish fruitful reading for many physicians, for gastrointestinal polyps are common, they are seen in patients in all age groups, and many aspects of their natural history and optimal management are still controversial. Doctor Welch reviews the literature in detail and draws upon both an extensive personal experience and an analysis of over 1100 polypoid lesions seen at the Massachusetts General Hospital in the period 1954-63. Superb roentgen and pathological illustrations contribute greatly to the text.

Although there are chapters devoted to lesions of the stomach and small intestine, the greater part of the book is justifiably directed toward consideration of the much more frequently occurring polyps of the colon and rectum. The importance of thorough bowel cleansing prior to roentgen examination is stressed, as is the wisdom of demonstrating a polyp on at least two examinations prior to operation. Emphasized also are the increased incidence of cancer when polyps are multiple and the definitely premalignant nature of the papillary (villous) adenoma.

From the standpoint of therapy, the author maintains firmly that "there are at this time only two indications for the expectant treatment of polypoid lesions in the good risk patient. The first, and more important, is that with a lesion less than 1 cm. in diameter, the risk of death following laparotomy may outweigh the risk that the lesion is cancer. The second is that small lesions with long pedicles (3 to 5 cm.) nearly always are clinically benign. However, even in these cases, a careful follow-up is essential to avoid serious errors".

This book is highly recommended as a balanced and up-to-date analysis of a complex and important area of clinical concern.

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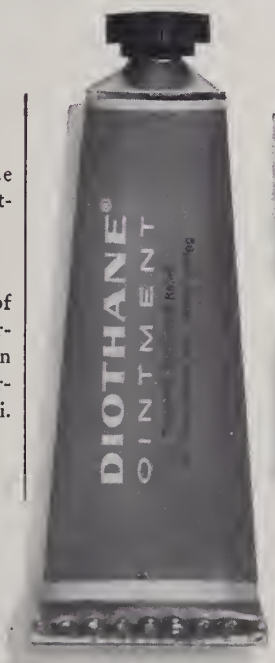
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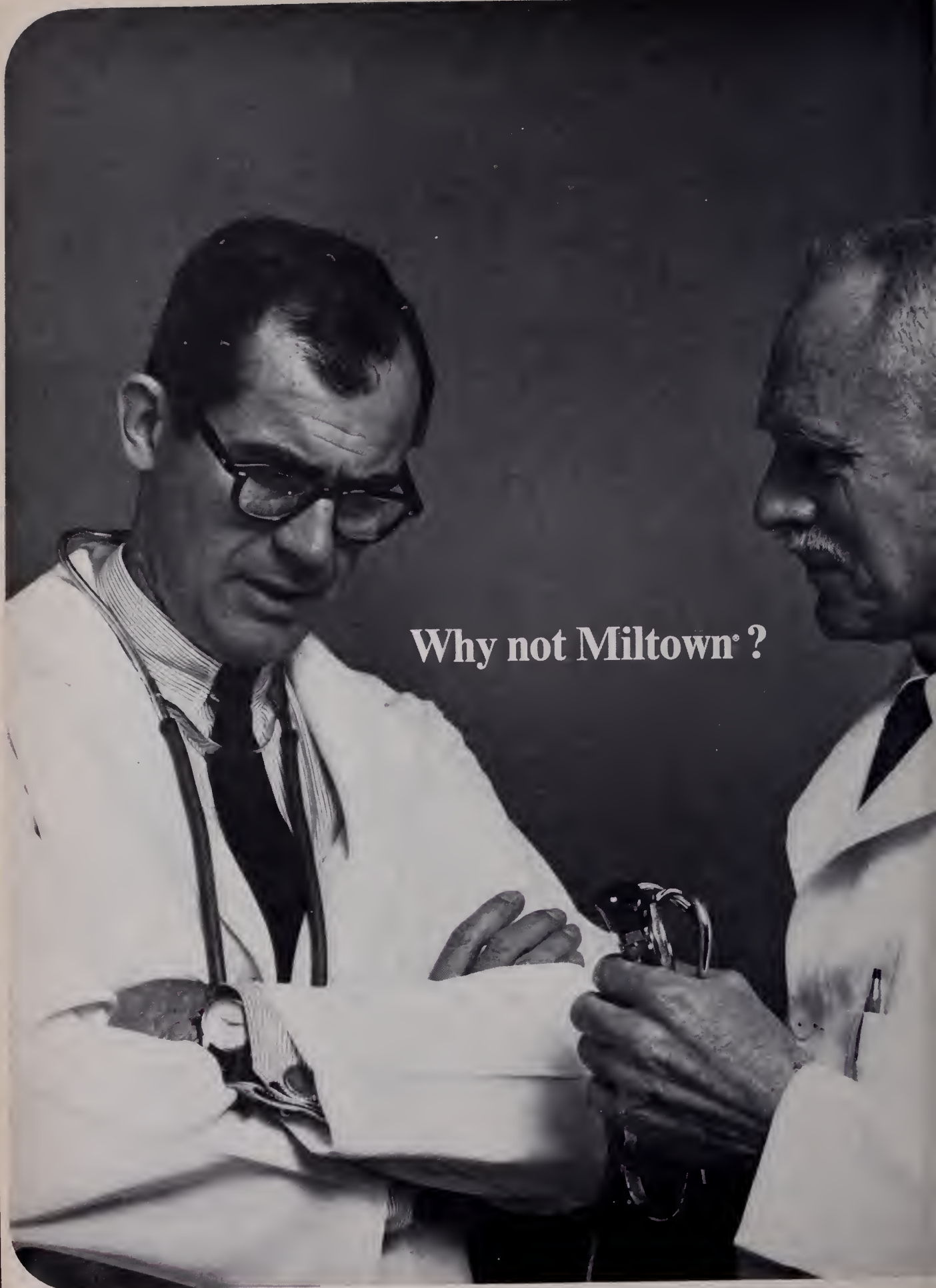
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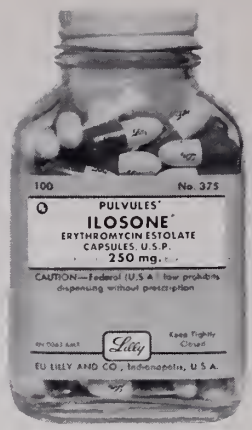
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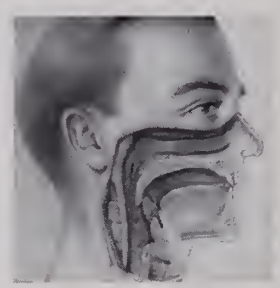
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Primary Enuresis in Children: A New Concept of its Cause and Treatment†

S. Richard Muellner, M.D.*

Boston, Mass.

Children with primary enuresis retain a bladder of infantile character, too small to hold the night urine. They therefore continue with enuresis. On this basis a new approach to treatment is proposed.

CHILDREN wet their beds at night for many reasons. Basically, however, bed-wetters can be divided into three main groups. In the first group are children who have congenital anomalies of the urinary tract and infections. These anomalies may affect the kidneys, the ureters, the bladder, the internal sphincter, the urethra and the meatus. Anomalies of the urinary tract are frequently associated with infections, but recurrent infections in an apparently normal urinary tract can also cause bed-wetting. The group of children whose enuresis is due to congenital anomalies and infections however is quite small. Congenital anomalies of the urinary tract are rare, and are seen in fair numbers in large children's hospitals only.

In the second group of children the enuresis is part of a complex, psychiatric behavior disorder. In this group, the entire behavior pattern of the child is abnormal and enuresis is but part of it. These children frequently have inadequate control of the urine during the day as well. Fortunately also, this group is rather small.

The vast majority of children who suffer from bed-wetting after the age of four and a half, when 88% of children in this age group have already developed excellent control both by day and by night, have what is known as primary enuresis. These children do not have any urinary tract infections, and their urinary tract is structurally normal, nor do they have serious psychiatric problems. This is by far the largest group of bed-wetters, and in the United States alone, there are about four and a half to five million children who suffer from primary enuretic children are "heavy sleepers" and lem that this paper will deal.

Of the 12% of children aged four and a half or older who continue with enuresis, 5% spontaneously stop their bed-wetting by the age of seven and a half. The old family doctors advice that the child will outgrow his enuresis, therefore has some basis in fact. It is well known, however, that many children do not do so and continue with enuresis after puberty and even into adult life. For this reason it is important to help them overcome their bed wetting as soon as possible.

Causes of Primary Enuresis

The cause of primary enuresis in children has not been known in the past. A few theories have been advanced to explain this phenomenon. The one given greatest credence is that enuresis. It is with this important clinical prob-therefore are unaware of their need to void.

†*Presented before the Kentucky Academy of General Practice at its annual meeting May 6-8, 1964.*

**Clinical Associate in urology at Harvard Medical School and acting chief of urology at Beth Israel Hospital, Boston.*

There are obvious faults with this concept. All children are "heavy sleepers" and, moreover, nocturia does not occur after night control has been established, except occasionally and for specific reasons.

Another assumption explains primary enuresis on the basis of inadequate development of "bladder nerves." The sympathetic nervous system plays an unimportant part in the physiology of micturition, and the parasympathetic nerve supply seems to be just as properly developed in enuretics as in normal children. Enuretics have normal bladder sensations and can start or stop their urinary stream at will. In fact, there is no evidence whatsoever that primary enuresis is due to any disturbance of bladder nerves.

There has also been a belief that too much and too vigorous or poor "toilet training" leads to enuresis. This belief also has no facts to support it. It will be shown later on that "toilet training" is totally needless and accomplishes nothing.

My own investigations on the development of urinary control in children have shown that primary enuresis is due to the improper development of the bladder capacity. Between the ages of two and four and one-half a child normally more than doubles his bladder capacity. The bladder then becomes large enough to hold the total output of night urine. If he fails to enlarge his bladder to the proper dimensions for his age and size, he will be left with a bladder that retains some of its infantile characteristics and is too small to hold the night urine.

An infant starts life with a small and automatic bladder; that is, when the bladder has reached its limit of fill, the stretch reflex is elicited, the detrusor contracts in response to the stimulus, and micturition proceeds until the bladder is empty. This type of micturition can be called "detrusor micturition" for it is mediated by the detrusor only. The will does not enter into this. By the age of four and one-half most children have acquired adult-like and complete voluntary control of their bladders. Some do not complete this process until they are six or six and one-half years old.

In the transformation from the infantile to the adult type of bladder control, a child must take four steps. At about the age of one, a child first becomes aware of the sensation of bladder fullness. This is due to maturation of the autonomic nervous system. Before long the child can communicate his desire to void. At this stage the child cannot as yet initiate or stop the urinary stream at will. The second step is the ability to "hold the urine" or to inhibit a detrusor contraction even for a brief period. The third step is the ability to start the stream when the bladder is full or nearly so. Most children have completed these three steps by the age of four or four and one-half. The fourth and the last step in the acquisition of complete voluntary control is the ability to initiate micturition at any degree of bladder filling. This is the most difficult step and is achieved between the ages of four and one-half and six and one-half.

The "voluntary mechanism," with which man subjects his involuntary (smooth) muscled bladder to the complete domination of his will, consists of the thoracic diaphragm, the abdominal musclature, and the levator ani with its pubococcygeus. By means of these muscles he creates intra-abdominal pressure which he directs toward his bladder neck to initiate the reflexes of micturition. To do so, the diaphragm is steadied at the end of a brief inspiration, the abdominal musculature is contracted, thus creating intra-abdominal pressure which is then directed precisely to the vesical neck. The pubococcygeus is relaxed at the same time, so that the bladder neck is pushed down in the pelvis. This downward push on the bladder neck initiates a detrusor contraction, the internal sphincter is opened as a result of the contraction of the detrusor, and micturition proceeds. To stop his stream at will, man simply contracts the entire levator ani (including the pubococcygeus)[1, 2]. By means of this maneuver he lifts the vesical neck, coapts the urethral wall, and stops his stream.

During the second stage, when the child learns to hold the urine for a brief time, he does so by contracting the levator ani. The child next acquires the ability to initiate a detrusor contraction when the bladder is full or nearly so. This he does through the use of the diaphragm and of the abdominal musculature.

In the fourth and last stage, when complete urinary control is achieved, he acquires the complex skill of coordinating the use of his diaphragm, his abdominal muscles, and the

separate use of his levator ani. He now can start or stop his urinary streams at any degree of bladder filling. The acquisition of the skill to start or stop the urinary stream at will is primarily the skill in creating and directing precisely intra-abdominal pressure and the skill in the separate use of the levator ani to interrupt or to stop the stream.

It will be apparent from the above, that this complex skill cannot be taught by parents. Toilet training as it is practiced, is needless, and is no more effective than teaching a child to walk or creep, which he learns without anyone's help. Indeed, Klakenburg in a careful study of three hundred and fifteen children showed that those who were "toilet trained" and those who were not, achieved urinary control at the same time[3, 4].

Once the child has mastered control of his detrusor, he begins to change and to enlarge his bladder capacity. My studies have shown that between the ages of two and four and one-half a child normally more than doubles his bladder capacity. This is the critical age, and whether a child will be dry at night or continue to wet his bed is determined during this period. By the age of four and one-half, the bladder of a normal child will hold eight to ten, or even fourteen ounces of urine, and he voids during the day in six- or seven-ounce amounts. The enuretic child continues to void in the pattern of a three-year-old and voids in two- or three-ounce amounts and at the most his bladder will hold five or six ounces. Even an occasional voiding of eight ounces is not enough to eliminate bed-wetting completely.

Diagnosis

The diagnosis of primary enuresis in a child of five or older who still wets his bed is quite simple. A careful history and a thorough physical examination and a urinalysis are, as a rule, sufficient. Children who have diseases or anomalies of the urinary tract have difficulty with day control as well. Their micturition pattern is abnormal. They void in small amounts and are apt to have a weak or interrupted stream. Those in whom abnormality of the urinary tract is suspected may need intravenous pyelography or a cystoscopy or retrograde pyelograms. Children who have pyuria particularly need a thorough urologic investigation.

Those in whom enuresis is part of a complex psychiatric problem can be readily recognized by any experienced clinician. If there is any doubt, the help of a psychiatrist should be sought.

It is helpful to establish a diagnosis of primary enuresis by using a "voiding chart" which is kept for a few days before any treatment is instituted. Such a chart records both the fluid intake and the urine output from the time a child rises in the morning until he retires at night. On one half of the chart is recorded the time and the amount of each fluid consumed. (The quality of the fluid whether milk, water, or fruit juice is immaterial.) A simple way to measure fluid intake is to bear in mind that a tumbler holds eight ounces, a cup, six ounces, a small juice glass, four ounces. An ounce or two left behind in a cup or in a glass can be readily estimated and the amount actually consumed recorded. For analysis of the micturition pattern, the child is asked to void into a glass measuring cup which holds at least fourteen ounces.

The child with primary enuresis tends to restrict his fluid intake so as to avoid urinary frequency during the day. The chart readily shows this and also reveals that the bed wetter voids in two-or three ounce amounts. A child of six or seven who can hold twelve or fourteen ounces of urine most likely does not have primary enuresis, and other causes must be considered.

Treatment

Once the diagnosis of primary enuresis has been established, an attempt can be made to enlarge the child's bladder capacity by distending the bladder with its own urine. To do so the patient is instructed to *force fluids during* the day, just the reverse of what had been taught in the past. He must also "hold the urine" as long as possible to increase his bladder capacity and the voiding volume. Whenever possible the child should void into the measuring cup to see if he can hold larger quantities of urine and to note his progress in this respect.

It is usually not difficult to get children to cooperate in this program unless they are too young or their bladder capacity is particularly small.

To facilitate the distention of the bladder, anticholinergic drugs are useful. Fortunately children can tolerate these drugs very well.

One tablet of atropine sulfate 0.4 mg. given in the morning, at noon, and at bedtime can be very helpful. The dose, of course, has to be adjusted for the age and size of each child, using however a dose which will produce physiologic results. Atropine has the disadvantage of dilating the pupil too much, and may thus interfere with schooling. Some of the newer drugs which have less side effects may have to be tried. Drugs such as Daricon (oxyphenylcic-lamine) hydrochloride which comes in a 10-mg. tablet (Pfizer) or a capsule of Prydon, 0.4 mg., (Smith Kline, & French) may be substituted for the atropine.

It is sometimes necessary to overcorrect a small bladder. Whereas a twelve ounce capacity and a voiding volume of eight or ten ounces during the day can be sufficient to eliminate enuresis in many children, for a more permanent cure, it may be desirable to reach the higher capacity of fourteen ounces. Children who are past puberty need an even larger bladder capacity to be rid of bed-wetting.

Like most diseases affecting man, enuresis may be mild, moderate, or severe. A husky boy of twelve anxious to get well, who cooperates fully, will distend his bladder quickly to a normal capacity. On the other hand, a delicate little girl of five, small-boned and sensitive, cannot readily cooperate with the regimen of forcing fluids or holding her urine too long, because of pain. The pace will, of necessity, have to be slower in her case, and this type of child must be treated with patience and sympathy. With persistence and encouragement, the enlargement of the bladder capacity, however, can be achieved in most children and enuresis can be readily eliminated.

There are a number of obstacles to the successful elimination of enuresis. A child whose parent takes very little interest in his problem and who will not take the trouble to make sure that the anticholinergic drugs are given on time and to encourage the child from time to time to hold and to void larger capacities, will have a more difficult time to clear his bed-wetting. In fact, the whole program may fall apart because of lack of interest. It is therefore important to detect this early and to see the child at frequent intervals. The problem of enuresis, in some ways resembles the problem of obesity. It is not dangerous and nobody dies from it, and like the obese, the parent of an enuretic child also wants a magic pill which will at once cure the condition. Since primary enuresis is a developmental delay which can be corrected only by a pains-taking and persistent effort, to enlarge the bladder, (a process which is quite dull and perhaps somewhat slow at times) it is necessary to stimulate and maintain the interest of the parent and the child to obtain a satisfactory result. It is important to emphasize that the drug is not the cure but only an adjunct to help the child distend his bladder to a larger capacity. Also it is not wise to prognosticate a rapid cure, even though in a given case the physician may feel confident of one in a short time. If the prognosis has been inaccurate, confidence in the regime and the doctor will be lost.

This method of treating enuresis has in my hands succeeded whenever the interest of the child and of the parent could be enlisted and maintained. Failures have been due entirely to half-hearted attempts, irregularity in the taking of the anticholinergic drugs, and a lackadaisical effort to force fluids or to hold urine.

The problem of bed-wetting in the post puberty period and in young adults is in some respect somewhat different from its counterpart in younger children, and will be the subject of another paper.

Summary

There are four and a half to five million children in the United States who suffer from primary enuresis. This type of enuresis is not due to anomalies or infections of the urinary tract or to psychiatric disorders. It is the most common type. Congenital anomalies of the urinary tract are comparatively uncommon. So are complex psychiatric disorders which affect the child's total behavior and in whom enuresis is part of the whole complex problem.

Children with primary enuresis develop day control of the bladder at a normal age but continue to wet their beds after the age of four and a half, at which time most children have developed complete control both by day and by night.

Our studies show that this type of enuresis is due to underdevelopment of the bladder capacity in children who are otherwise normal. Primary enuresis can be eliminated if the bladder capacity is enlarged commensurate with the childs' age and size. To do so the child

(Continued on Page 300)

Current Concepts of Renal Tuberculosis†

HERMAN WECHSLER, M.D.*
Bronx, N.Y.

Renal tuberculosis is usually a blood-borne disease, secondary to pulmonary involvement. Current chemotherapy has been so successful that surgery is no longer necessary except in rare conditions.

RENAL tuberculosis is a disease which is not going out of fashion. In our hospital** the number of new admissions with this disease continues to be surprisingly steady. Since renal tuberculosis is usually secondary to pulmonary or hilar tuberculosis, and may take from 5 to 20 years to develop, it is apparent that a large potential reservoir of kidney disease exists in every community. The number of cases found depends mainly upon the family physician being aware that this condition exists and will not disappear in our lifetime. (Figure 1)

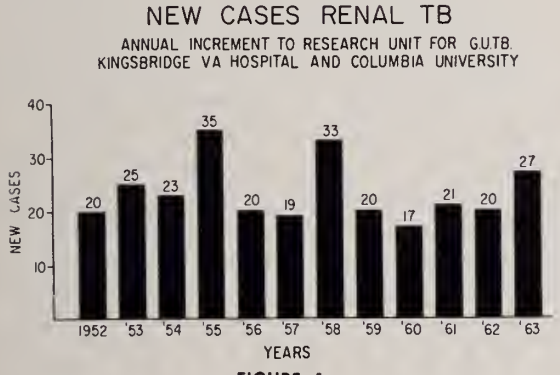


FIGURE 1

The greatest number of cases is found in the age group of 20 to 40. Until five years ago, there was a continuous drop by decades in the number of admissions. However in the age group of 60 to 75, there has been a sharp rise so that this group now accounts for the second greatest number of cases with renal tuberculosis.

Renal tuberculosis is a blood borne disease. It occurs bilaterally and probably simultaneously. That both kidneys develop tubercles was well shown by Medlar[1], who studied serial sections to demonstrate the pathology. It is difficult to determine the reason that permits one kidney to heal or remain in a state of quiescence, while the other may go on to caseation and necrosis. Figure 2 demonstrates the course of the disease if permitted to remain untreated. In the age before chemotherapy, this was the usual sequence of events and too often was bilateral.



FIGURE 2

Diagnosis

Early diagnosis, as with other disease, is of paramount importance. The finding of pyuria, otherwise unexplained, should alert the physician to the possibility of tuberculosis. A smear will rarely be of value. Culture of the urine, repeated as often as possible, is essential to the proper diagnosis. Unpublished studies indicate that a morning specimen will serve as well as the 24 hour urine. This also helps to obviate the chance of contamination. In the patient with negative cultures, where the physician feels strongly that tuberculosis is present, a guinea pig inoculation will often prove of great help. Rarely will one find a laboratory able and willing to perform multiple inoculations.

†*Presented at the April 23, 1964 meeting of the Kentucky Thoracic Society at Louisville.*

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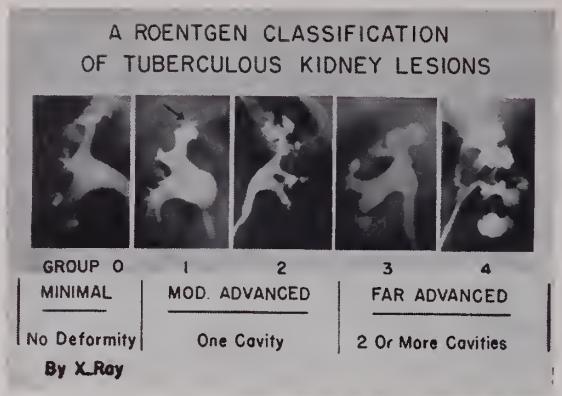


FIGURE 3

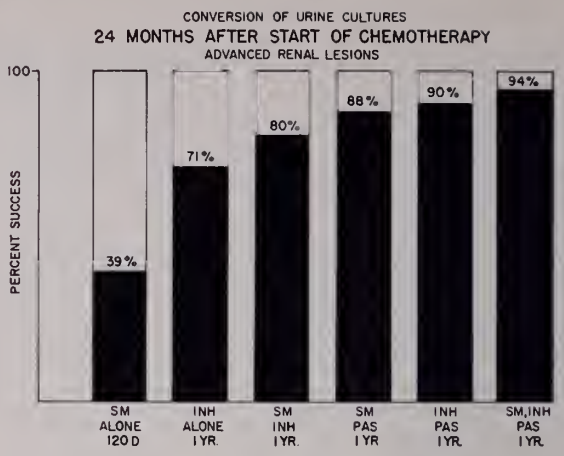


FIGURE 4

The most important signs and symptoms[2] are epididymitis, painless hematuria, renal colic, frequency of urination, burning and dysuria. Months to years may pass before a patient will seek medical advice or before the doctor will institute complete studies to arrive at a diagnosis. In many patients, the removal of a mass, either kidney or epididymis, may surprisingly give the diagnosis microscopically. In retrospect one can piece together the history. It must be remembered that a patient may present only one symptom although combinations do occur. If the above symptoms are kept in mind and are not adequately explained, the search for M. tuberculosis may be quite rewarding.

Treatment

Treatment may consist of various regimens, all of which have proved successful. A helpful guide is the roentgen classification, proposed by Lattimer (Figure 3). In a minimal lesion, two-drug therapy may give most satisfactory results. It has been shown that multiple drug therapy will provide effective treatment and will offer less chance of provoking drug resistance. Triple drug therapy has proven to be the choice of treatment in renal tuberculosis[3]. Treatment should be given continuously for two years and if necessary, it can safely be continued for longer periods of time. Drug sensitivity tests are done when the cultures are positive for M. tuberculosis. This will help to eliminate a drug which apparently will not be satisfactory. As will be seen from Figure 4, there is an increasing amount of salvage possible by using triple drug therapy. When continued for two years as is now advocated, the percentage of success is even greater.

Examples of satisfactory regimens are:

Isoniazid (INH) 100 mg. three times a day
Sodium aminosalicylic acid (PAS) 5 gms. three times a day
Streptomycin, 1 gm. injected twice a week
Pyridoxine 50 mg. twice a day.

It is important that audiometric tests be done first to obtain a base line. If indicated kanamycin may be substituted for the streptomycin. I have found it satisfactory in some cases. The use of dihydrostreptomycin has not proved to be successful and indeed is more toxic to the eighth nerve.

Another regimen I have found useful is:
INH—100 mg. three times a day
PAS—5 gms. three times a day
Cycloserine (CS)—250 mg. twice a day
Pyridoxine 50 mg. twice a day.

An important advantage is that this regimen avoids injections and thus patient acceptance is greater. With this dosage of cycloserine, I have found no patient has developed central nervous system complications. When first advocated, this drug was given in a daily dose of one gram and many side effects made the patient and his doctor unhappy.

When drug failure has resulted or resistance has occurred, ethionamide may be offered. At present, FDA rules prohibit its use in primary treatment but it may be given in a secondary regimen as follows:

INH—100 mg. three times a day
CS—250 mg. twice a day
Ethionamide—250 mg. three times a day
Pyridoxine 50 mg. twice a day.

With the use of ethionamide, a base line of liver function studies must be established, particularly serum bilirubin, SGOT and alkaline



FIGURE 5

phosphatase. These should be repeated at monthly intervals and if a rise in the values occurs, it should serve as a warning to repeat the tests more frequently or discontinue the use of ethionamide. Liver damage which follows is reversible upon removing the drug from the regimen. It will be noticed that pyridoxine is included whenever INH is used. This has been found most valuable to prevent the neuritic complications which may occur with isoniazid.

Surgery

Surgery, in my opinion, has very little to offer. To remove a kidney in the hope of preventing further infection is of no value, since tubercles are present in both kidneys. The kidneys shown in Figure 5 can support life and until transplantation opens a new era, is best left in the patient. At present our service has been carefully watching eight patients, each with a non-functioning kidney. Not one has shown signs of toxemia, hemorrhage or enlargement of the kidney for as long as ten years. Nor has surgery been done for epididymitis. Even

MORTALITY IN BILATERAL RENAL TB

3-5 Year Follow Up

No Treatment	Sporer, 1946	81%	(4 Yrs)
	Nesbit, 1945	81%	(3 Yrs)
	Emmett, 1938	60%	(5 Yrs)
	Parsons, 1925	85%	(5 Yrs)
Chemotherapy	This Study, 1954	8%	(5 Yrs)

FIGURE 6

those with a draining sinus have healed with competent chemotherapy. Large masses have usually shrunk to a small size and become non-tender.

Partial nephrectomy[4] was utilized for a time in suitable cases when the lesion was confined to one pole of a kidney. However, as knowledge and experience with chemotherapy increased, even this surgery has been withheld in favor of chemotherapy. As can be seen in Figure 6, the advent of chemotherapy has meant a substantial saving of lives and a marked decrease in morbidity. With better understanding and cooperation upon the part of the patient, this improvement should continue to rise.

Summary

The incidence, pathogenesis, symptoms and signs of renal tuberculosis are presented. Chemotherapy has proven so successful that surgery may be withheld even for advanced renal tuberculosis.

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The Role of Anterior Interbody Fusion in Acute Injuries of the Cervical Spine

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Lexington, Ky.

Anterior interbody fusion has certain advantages over conventional skeletal traction in the treatment of cervical spine injuries. The rationale, surgical technique and results of the procedure are discussed.

ANATOMIC disruption of the spinal cord produces irreversible loss of function subserved by damaged neural pathways. Until some method for restoring axonal continuity is developed, therapeutic efforts will remain confined to the preservation of life and the full development of residual function. The broken neck must be brought into alignment and kept in this position until firm union between the damaged parts has taken place with the objectives of stability, protection of contained nervous tissues and freedom from pain. Anterior interbody fusion is a procedure which has distinct advantages over other methods for achieving these ends. It is the purpose of this report to present these advantages in the light of personal experience with eleven cases. Injuries involving the atlanto-axial articulation will not be considered because anatomical factors preclude application of the approach above the C_2 - C_3 intervertebral space.

Rationale

Bailey[3] has shown the primary role of the intervertebral disc in maintaining stability of the cervical spine. Disruption of one or more intervertebral discs occurs in many fractures and fracture-dislocations. With the type of fracture-dislocation resulting from flexion injuries the disc is usually torn from its attachment to the upper vertebral body. The line of disruption may be either along the plane of junction of the disc with the cartilage end-plate or at the interval between the end-plate and the vertebral body. The strong anterior longitudinal ligament may be torn at the same point. These changes have been observed during the course of anterior operations and at the time of post-mortem study.

Minor trauma may result in recurrence of the deformity following reduction of cervical fracture-dislocations because of imperfect repair through the area of intervertebral disc disruption[3, 4, 14, 15, 20]. Spontaneous fusion occurs in one-half of fracture-dislocations following satisfactory reduction[14] but does not occur in the remainder either because of the interposition of fragmented disc or because of excessive movement between vertebral bodies. The consequences of instability may be painful movement of the neck, compression of nerve roots at the involved vertebral level, and acute or chronic injury to the spinal cord.

The definitive treatment of injuries to the cervical spine by skeletal traction is based upon the concept that healing of soft tissues rather than bone is responsible for holding the vertebrae in correct alignment[8]. Crutchfield adopted a six-week period of traction on the basis of clinical experience indicating that sufficient healing had occurred in this time to maintain alignment after the application of a cervical support. The correctness of his views has been verified by Brav, Miller and Bouzard[4] who reported redislocation in 14.2% of injuries when traction was maintained for less than six weeks and redislocation in only 2.3% when traction had been continued for six weeks or longer. However, certain fracture-dislocations cannot be reduced by skeletal traction and in others reduction cannot be maintained.

Non-operative reduction can be achieved in

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**Presented to the Kentucky Chapter, American College of Surgeons, at their annual meeting April 24 and 25, 1964.*

the great majority of cervical fracture-dislocations, but restoration of vertebral alignment is not the sole objective in the management of these injuries. Objections to skeletal traction and external support as the definitive treatment for all injuries of the cervical spine have been raised during the course of 31 years since the method was introduced.

1. Confinement to a bed for six weeks is costly in terms of time and money.
2. a small number of patients may have residual neck pain,
3. late subluxation may occur with resultant injury to the spinal cord or nerve roots (Southwick and Robinson)[20],
4. intervertebral disc fragments may herniate into the spinal canal compressing the anterior surface of the spinal cord and nerve roots[6],
5. the acute and chronic consequences of "tear-drop" fractures are not circumvented by traction[16],
6. the syndrome of chronic injury to the cervical cord in the region of the central canal described by Schneider can occur in a mobile spine[17].

Operative Stabilization

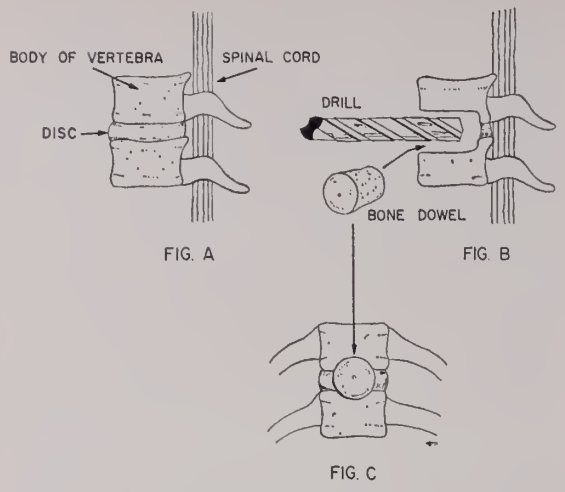
Robinson and Southwick[14] reported the advantages of early fusion in the treatment of cervical fracture-dislocations. They employed two different techniques for posterior fusion. Following reduction of any dislocation, the articular facets were wired to bilateral tibial bone struts in cases in which the neural arch was intact. The other procedure, applicable to flexion injuries requiring laminectomy, employed wire reins passed through drill holes in the articular facets and fixed to the T1 spinous process, followed in three weeks by an anterior fusion of the vertebral bodies.

Forsyth, Alexander, Davis and Underdal[9] employed posterior wire fixation and fusion for acute cervical fracture-dislications. Brav, Miller and Bouzard[4] also reported the use of posterior fusion in acute injuries. The procedure was performed at a late stage in 11.1% of their patients because of redislocation or the later development of neurologic complaints. Johnson[11] also recommended posterior spinal fusion for acute injuries of the cervical spine. The techniques for posterior spinal fusion are similar, all involving wire fixation of a bone graft to raw cancellous bone and postoperative immobilization until fusion has taken place.

Bailey and Badgley[1] utilized an anterior approach to the vertebral bodies when satisfactory reduction had been obtained by means of skeletal traction. Fragmented disc material was removed and replaced with bone chips, and a trimmed iliac bone graft was held in a trough cut in the anterior aspects of the vertebral bodies with sutured prevertebral fascia. Traction was continued for six weeks and a brace was worn for four to six months afterwards. If reduction was not successful, because of locked facets, operative reduction and simultaneous posterior fusion were undertaken.

Cloward[6] reported eleven patients with acute fractures and fracture-dislocations treated by vertebral-body fusion through an anterior approach. Using a technique described earlier for the treatment of ruptured cervical discs, interbody fusion and stability were achieved by inserting a bone dowel into a half-inch drill hole centered over the involved vertebral interspace. The operation was performed as soon as the patient's general condition permitted, usually within a few days of the injury. Skeletal traction was instituted at the time of admission and continued until the end of the operation when it was removed. Postoperative activity was restricted only by neurologic disability and postoperative bracing was limited to a plastic collar. Operative reduction was successfully carried out in those cases in which closed reduction with skeletal traction had failed. Although anterior angulation at the site of fusion occurred in several patients it was not accompanied by any functional impairment. Postoperative anterior angulation was avoided in a later series of 17 patients with simple dislocation by using a vertebra spreader to introduce a five-eighths-inch dowel into the half-inch drill hole[5]. Cloward's method eliminated prolonged traction and bracing and hospitalization was reduced to less than a week for patients without spinal cord injury.

Verbiest[21] managed badly comminuted vertebral bodies by removal of the involved body and adjacent intervertebral discs and replacement with a tibial bone graft wired to the intact vertebral bodies. Cloward's technique for interbody fusion cannot be used when a vertebral body is badly comminuted or crushed because firm fixation of a preformed dowel depends



FIGURES A, B, and C. Technique of anterior interbody fusion. A. Alignment of the vertebral bodies has been achieved by preoperative skeletal traction. B. Drilling is nearly completed, only a thin shell of bone remaining between the drill point and the posterior longitudinal ligament. C. Iliac bone dowel is shown in place.

upon its compression by contiguous vertebral bodies. The procedure described by Verbiest, therefore, can be utilized in the small number of cases unsuited for anterior interbody fusion in Cloward's operation.

Smith and Robinson[19] described anterior removal of an intervertebral disc and interbody fusion using a bone plug as a mechanical strut. Their method differed from Cloward's in two respects: the disc was excised without drilling into the adjacent vertebral bodies, and their iliac bone plug was fashioned "free-hand" rather than removed with a standard plug cutter. Herzberger et al.[10] applied this procedure to traumatic disorders of the cervical spine and reported their results in 1962.

Surgical Technique

The anterior surface of the vertebral bodies is exposed through a transverse skin incision. The involved interspace is easily identified by alternately increasing and decreasing the amount of skeletal traction and observing instability at the site of the injured disc. (Figure A). Weight up to 30 pounds is added to the traction apparatus to widen the interspace and loose disc fragments are removed. The posterior longitudinal ligament is then exposed by stepwise alternate drilling and removing disc material (Figure B). Free disc fragments may be found within the spinal canal and can be removed under direct vision.

When reduction has not been achieved prior to surgery, the dislocation may be corrected by increasing the amount of traction while wedging the vertebrae apart with an instrument in the interspace. This is not always successful and in a recent case incomplete reduction had to be accepted.

Finally, a dowel removed from the patient's iliac crest is fitted into the drill hole and weights are removed (Figure C). Stability of the dowel can be judged by direct observation. Because of hyperemia associated with fresh injuries the wound is drained for 24 hours. Skull tongs are removed before the patient leaves the operating room.

The patient is permitted to sit up or walk on the day following surgery. A light plastic collar is worn for one to four weeks but no other form of immobilization has been used. Discomfort in the neck is slight and is often overshadowed by pain at the iliac graft site. This latter complaint is minimized by disturbing the periosteal muscle attachment as little as possible when taking the bone dowel.

Present Series

Eleven patients with cervical fracture or fracture-dislocation have been treated by anterior interbody fusion.* The level of injury was at C_2 - C_3 in two cases and the remainder were lower. Laminectomy was performed in one case and an anterior fusion followed several days later.

Complications were encountered in two cases. In one, an anterior subluxation of C_6 on C_7 could not be completely corrected at the time of surgery. Stability was achieved although there was some angulation of the spine. This spinal deformity was unimportant because immediate complete interruption of spinal cord function had persisted during the five-day period between injury and operation. The second complication resulted from an error in judgment. The lesion was a fracture-dislocation of C_2 on C_3 which had been completely reduced by skeletal traction. At the time of surgery, the C_3 - C_4 intervertebral disc was found to be damaged and fusion was performed at this level. The mistaken level of fusion was evident on a radiograph taken the following day. Dur-

Eight patients were treated on the Tulane Neurosurgery Service, 1959-1961, under the direction of R. C. Llewellyn, M.D. Three patients have been treated at the University of Kentucky Medical Center.



FIGURE D. Lateral radiograph showing bilateral pedicle fractures and anterior dislocation of C_2 on C_3.

ing the course of a second operation friable pharyngeal mucosa was torn and the procedure was abandoned. The wound healed uneventfully following repair of the torn mucosa but no further attempt was made to fuse the C_2 - C_3 intervertebral space.

One case history will be used to illustrate the low morbidity of the procedure and the advantages of shortened hospitalization and early resumption of activity.

U. H. #01-23-52. A 34-year-old male was referred to the University Hospital on 7-13-63 with a diagnosis of fracture-dislocation of the cervical spine. Radiographs which accompanied the patient showed fractures of both pedicles of C_2 with anterior displacement of the C_2 vertebral body (Figure D). Crutchfield tongs were applied with 15 pounds of weight and reduction had occurred by the following day. There was no evidence of damage to the cervical spinal cord and the patient's sole complaint was severe neck pain. The fracture was considered unstable and on 7-19-63 an anterior interbody fusion was performed at the C_2 - C_3 level. The intervertebral disc was found to be fragmented and sheared completely from the inferior surface of the C_2 vertebral body and the C_2 vertebral body could be displaced forward by gentle manipulation. With the bone dowel in place and traction removed, the spine was stable. He walked out of the hospital on the fourth postoperative day wearing a plastic Thomas collar. Early bony fusion was evident five weeks later and the collar was discarded. (Figure E). He resumed full activity ten weeks following injury.

Summary and Conclusions

Experience with eleven cases of acute fracture-dislocation of the cervical spine treated by anterior interbody fusion has shown the value of early internal fixation in the management of these injuries. Elimination of prolonged skeletal traction permits early activity. The use of a form-fitted bone dowel results in immediate stabilization and postoperative bracing has not been necessary.

Damage to the intervertebral disc is the primary factor responsible for instability. Removal of the injured disc provides direct access to the spinal canal which may contain fragments



FIGURE E. Lateral radiograph showing early interbody fusion at the C_2-C_3 interspace at five weeks.

of bone or disc material. The operative procedure is well tolerated in the early post-injury period and no patient has been made worse as a consequence of early operation. Solid bony fusion eliminates the problems of redislocation and residual pain which may occur following treatment by skeletal traction alone. Skeletal traction as described by Crutchfield remains the cornerstone of treatment for all major injuries of the cervical spine. However, subsequent management by anterior interbody fusion offers distinct advantages to the patient.

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Carotid-Vertebral and Cerebral Arteriography

T. R. Marshall, M.D.* and J. T. Ling, M.D.**

Louisville, Ky.

A safe and simple method of visualization of the neck and cerebral vessels in patients with cerebral vascular occlusion is presented.

THIS paper consists of a discussion of the common current methods of performing carotid — vertebral and cerebral arteriography and indications for each particular procedure. Emphasis is placed on the ease and safety of percutaneous non-catheter brachial and axillary arteriography. Occlusive disease of the carotid artery is more prevalent as a cause of cerebrovascular accidents than most clinicians suspect. Awareness of the possibility of occlusion in a major surgically accessible artery will allow earlier recognition of the condition. This makes possible prompt arteriography when necessary and appropriate surgery to relieve the arterial occlusion.

The advantages and disadvantages of each method of arteriography will be discussed. For an orderly presentation, the methods are divided into two separate groups. *Non-catheter* procedures and *Catheter* procedures. The common non-catheter procedures employed are: (1) percutaneous common carotid arteriography, (2) percutaneous vertebral arteriography, (3) percutaneous subclavian arteriography, (4) percutaneous axillary arteriography and (5) percutaneous brachial arteriography. The common currently employed catheter methods are: (1) catheterization of the common carotid artery, (2) vertebral artery injection by catheterization of the femoral, brachial or axillary artery, (3) subclavian artery catheterization and (4) axillary and brachial artery catheterization.

Non-Catheter Methods

Percutaneous Common Carotid Arteriography was introduced by Moniz[1], in 1927, who performed the procedure by direct exposure of the common carotid artery. Percutaneous puncture soon supplanted this method because it was a relatively easy skill to develop. The value of this method has been demonstrated throughout the United States and the world in the past 37 years. Since its introduction the development of newer and less toxic contrast media has contributed significantly to the lower mortality rate. Up to 15 years ago the overall morbidity rate from this procedure varied from one per cent to three per cent depending upon the selection of the patient, and what particular type of complication was considered as a result of the procedure. At the present time the morbidity rate is well under .5%.

The accepted procedure consists of the percutaneous insertion of a 17 to 18 gauge needle into the common carotid artery and injection of 8 to 10 cc. of a 28 to 29% contrast material. Usually a series of four or five injections is made to obtain AP, lateral, and modified Towne views. Extravasation of contrast medium is a fairly common mishap, and sometimes vessels are entered unintentionally, particularly the vertebral artery. Subintimal injection occurs in approximately three to four per cent of the injections and when marked can produce an intimal flap and sudden death. Lesser degrees of subintimal injection result in damage to the intima and media of the artery.

Percutaneous Vertebral Arteriography — Many deaths have been attributed to this procedure because of the difficulty of puncturing the vessels directly because of inaccessible location and the fact that the vertebral artery does not tolerate puncture and contrast media seem to produce more irritation in the vertebral-basilar artery complex[2]. This method should be mentioned only to be condemned. Usually most of the direct vertebral artery injections are accidental and occur during an attempt to puncture the common carotid artery when the vessel is small or puncture is performed by inexperienced persons. Dura penetration and needling of the cervical spinal roots are among the

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FIGURE 1—Right brachial artery injection, using 25 cc. of meglumine iothalamate 60% and 90 p.s.i. gauge pressure with a Marshall Automatic pressure injector.

hazards. Direct injection does not distinguish the origin of the vertebral artery from the subclavian nor can the opposite vertebral artery be visualized without compression.

Percutaneous Subclavian Arteriography — The method consists of the percutaneous insertion of a 17 or 18 gauge needle directly into the subclavian artery near the clavicle. Injection may be performed by hand or with an automatic pressure injector. Visualization of the neck vessels and cerebral circulation can be obtained. This method affords visualization of the vertebral artery on the side of injection. Usually 10 to 20 cc. of a 28 to 29% contrast material are injected. This method has gained considerable popularity outside of the United States. Subcutaneous emphysema, pleural or mediastinal hemorrhage and intercostal neuralgia are among the many complications attributable to subclavian arteriography[3].

Percutaneous Axillary Arteriography — The first reported use of direct axillary artery injection in performing cerebral arteriography was described in 1963[4, 5]. The axillary method does not differ from the brachial artery method except for puncture of a different vessel. The results obtained are very similar to brachial percutaneous puncture except that there is a slightly greater incidence of filling of the left common carotid artery from the right axillary artery injection.

Percutaneous Brachial Arteriography—This method was described by us in 1963[5, 6] and is now widely used. (Fig. 1). Its main advantages are that a catheter does not have to be used, and visualization of the cervical-carotid vessels can be obtained from a single injection. (Fig. 2). The advent of the era of vascular surgery and the emphasis on the fact that approximately 20% of strokes are due to occlusive disease of the cervical-carotid vessels led to the development and widespread acceptance of this method. The method consists of the percutaneous insertion of a 17 gauge vascular needle (B-D and Co., 01-0062) into the brachial artery at a line 1 cm. above the eipcondylar process of the humerus. The site of puncture is infiltrated with one per cent Xylocaine. Here the artery is very superficial and is held firm by the laceratus fascia. For infants and children a 19 or 20 gauge needle is employed. It is essential that the needle be threaded up the brachial artery for a distance of no less than 3 cm. A polyethylene or Teflon connecting catheter is employed from the needle to the automatic pres-



FIGURE 2—Modified Towne view showing filling of the anterior, middle and posterior cerebral arteries. The basilar artery appears normal.

sure injector. The Marshall automatic pressure injector is employed at a pressure range between 90-100 p.s.i. gauge pressure (Fig. 3). 15 to 30 cc. of meglumine iothalamate 60% are employed. In performing cerebral arteriography no compound containing over 29% iodine should be used. The only exception is when one uses a catheter in the aorta, a compound of 40 to 48% iodine must be used because of dilution by the blood flow in the transverse portion of the aorta. This is one of the shortcomings of this particular technique and accounts for its higher incidence of side effects, consisting of head rotation and seizures.



FIGURE 3—Origin of the left common carotid artery from the innominate artery. This has been seen in three per cent of our patients. There is filling of the left subclavian artery.

Catheter Methods

Catheterization of the Common Carotid Artery—A small polyethylene or Teflon catheter in inserted into the common carotid artery approximately 2 cm. below the bifurcation after direct puncture of the vessel with a 17 to 18 gauge needle. The needle is removed and the catheter is advanced up the artery for a distance of at least 3 cm. The catheter prevents extravasation and subintimal injection of the contrast material. Also there is no risk of dislodgement of the needle during injection[7].

Films are obtained in the AP, lateral and modified Towne views. Eight to 10 cc. of a 28% iodine solution are injected by hand or with an automatic pressure injector. By insertion of an 80 cm. thin guide wire with a flexible tip through an 18 gauge needle proximally in the common carotid artery followed by the passage of a Teflon catheter over the guide wire, visualization of the origin of the vessels of the aortic arch may be obtained. This method was recently described by Gonzalez[8] who reported no cerebral complications in 52 patients. This method has a potential major disadvantage in that if thrombosis of the common carotid artery should occur as a result of the procedure there would be impairment of the cerebral circulation.

Vertebral Artery Injection by Catherization of the Femoral, Brachial, or Axillary Artery—Vertebral artery injection is performed in younger patients by catheterization of the left vertebral artery from one of the above sites using usually a green (I.D. 1.3 mm) Odman-Ledin catheter. This can easily be seen in the cervical region by fluoroscopy. In adults, vertebral angiography is usually performed by the direct percutaneous method. In patients under the age of forty, the catheter tip will usually pass directly into the left vertebral artery[9].

Catheterization of the right vertebral artery is attempted by the brachial route in younger patients before the direct percutaneous vertebral puncture method is used. A red (I.D. 1.15 mm) Odman-Ledin catheter is used with a bend about 1 cm. from the tip. It is easier to introduce the tip of the catheter into the right vertebral artery than into the left from the brachial route because of the perpendicular course of the right vertebral artery in relation to the subclavian. On the left side the vertebral and subclavian arteries form an acute angle. Manual or automatic injection of 5-10 cc. of meglumine iothalamate 60% is carried out.

Subclavian Artery Catheterization — Using the modified Seldinger technique[10] puncture is made in the subclavian artery. A red Odman-Ledin catheter is introduced and advanced to the desired location. 20-30 cc. of meglumine iothalamate 60% is injected using an automatic pressure injector. Puncture is more difficult and is associated with a high incidence of pneumothorax. Hemorrhage from the puncture



FIGURE 4—Opacification of both common carotid, vertebral, and subclavian arteries. In this patient a true four vessel study was obtained.

site is frequent because it is difficult to compress the vessel. In general it has the same complications as the non-catheter methods, with more chance of hematoma formation at the puncture site and perforation of the vessel by the catheter.

Axillary and Brachial Artery Catheterization—The method consists of the percutaneous insertion of a 17 gauge needle in the brachial artery 1 cm. above the epicondyle of the humerus or the axillary artery high in the axilla[11]. Usually a 5-6 mm. incision is made into the skin to aid in passage of the catheter. The Seldinger technique of arterial catheterization is used. An automatic pressure injector is used to deliver the contrast medium rapidly to the aorta.

The axillary artery is larger than the brachial artery, but it is deeper and more movable. A larger hole is required in the vessel because of the larger size of the catheter than the needle that is used for direct injection. You are more likely to lose the radial pulse and there is a greater chance of an arteriovenous fistula between the brachial artery and vein or damage to the median nerve. The needle is larger by necessity, because the guide wire which has to be inserted is larger.

Discussion

The symptomatology of carotid insufficiency is as follows: (1) transient contralateral hemiparesis (small strokes), (2) transient monocular amblyopia (intermittent blindness) and (3) transient contralateral hemisensory change. The symptomatology of vertebral-basilar artery insufficiency is: (1) transient vertigo, (2) transient dysarthria, and (3) dysphagia. For a thorough study these patients should have a complete neurological examination, E.E.G., skull and cervical spine x-rays, ophthalmodynamometry, and angiography.

The easiest and safest method of performing carotid-vertebral and cerebral arteriography is by percutaneous puncture of the brachial or axillary artery. It is the only satisfactory method of visualization of the vessels of the arch of the aorta without the use of a catheter (Fig. 4). Injection of the right brachial artery gives visualization of the innominate artery, right common carotid artery, subclavian artery, vertebral artery and cerebral circulation. Left brachial artery injection (pan-arteriography) permits visualization of the left vertebral artery, thoracic aorta, abdominal aorta and its branches, and arteries of both lower extremities from one injection. Filling of the left common carotid artery is obtained approximately 15% of the time from a right brachial artery injection and 5% of the time from a left brachial artery injection. Application of a blood pressure cuff around the left arm during a right brachial artery injection will increase the incidence of filling of the left common carotid artery. The left common carotid artery was found to arise from the innominate artery in three per cent of the patients.

Since the introduction of the technique, 650 right and left brachial (cerebral) arteriograms have been performed at our institution by interns, residents and staff with only one fatality and a very low incidence of side effects. A patient having a right brachial artery study for occlusion of the middle cerebral artery had cardiac arrest shortly after the injection of the contrast material and died in spite of appropriate treatment.

There is no method at the present time that will give a true and satisfactory four vessel

study. Many patients can be examined by one or more of the methods discussed, however, the safest and simplest method giving the most desirable results should be chosen. In the catheter techniques failure to achieve proper positioning of the catheter is not uncommon. In the so called "arch study" with a catheter in the arch of the aorta satisfactory visualization of the distal extent and in particular the cerebral distribution of the carotid and vertebral arteries has usually not been possible.

The technique of percutaneous transcarotid thoracic aortography is useful when the transfemoral or transbrachial approaches are not possible, but should not be used in preference to the percutaneaus non-catheter brachial or axillary artery techniques.

Summary

The safest and simplest method for carotid-vertebral and cerebral arteriography (four vessel studies) is percutaneous non-catheter right and left brachial or axillary arteriography in combination with direct injection of the left common carotid artery when filling is not obtained of this artery. Six hundred and fifty patients have been examined by this method. The incidence of side effects is low. Many of these patients were in a poor condition as a result of vascular occlusion.

There are many catheter techniques which may give satisfactory studies. However, because of the advanced age group of these patients, catheter studies are usually extremely difficult, are associated with a higher complication rate and require greater skill. In addition, dislodgement of arteriosclerotic plaques and perforation of vessels is a real possibility.

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CASE DISCUSSIONS

From The

University of Kentucky Hospitals



Renal Homotransplantation: A Case Report

Don C. Pearl, M.D.* and Nancy H. Holland, M.D.**

SINCE the first successful human kidney transplant in 1954[1] there has been widespread interest in the possibility of treating patients in the terminal stages of renal failure by kidney transplantation. Calne and Murray demonstrated that the rejection of a homotransplant could be inhibited by the administration of azathioprine[2]. Studies published by Hume,[3] Murray,[4] and Starzl[5] have demonstrated the usefulness of small doses of X-ray delivered to the transplant, actinomycin C, and prednisone in preventing and reversing homograft rejection, utilizing various combinations of these adjuncts. There are now a few patients with normally functioning kidney homotransplants 18 months to two years following transplantation. The following case report is of the first kidney homotransplant to be performed at the University of Kentucky Medical Center.

Case Report

This 11 year old boy was admitted to the University of Kentucky Medical Center in January and again in March of 1964 because of chronic renal failure secondary to congenitally hypoplastic kidneys. His BUN ranged between 100 and 160 mgm% during these admissions. He was anemic, with a hemoglobin as low as 3 gm%, and acidotic, with a CO_2 content of 12 mEq/L. Treatment of anemia and acidosis resulted in improvement in his general condition during these first two admissions, but no lessening of uremia. He was admitted for the third time on May 28, 1964 because of anemia, generalized edema, congestive heart failure, hypertension, convulsions and coma.

On admission, he appeared to be acutely and chronically ill. He was pale, disoriented and obtunded. His blood pressure was 180/118. There was a Grade 3 systolic murmur over the precordium. There were fine rales over the lower lung fields. The liver was slightly enlarged. He had generalized edema. Neurologic examination was normal except for his lethargy and disorientation. Laboratory studies showed a hematocrit of 28% and a white blood count of 9100. The urine specific gravity was 1.010, BUN 170 mgm% and serum creatinine 8.5 mgm%. His condition gradually deteriorated with the BUN rising to 200 mgm%, sodium to 150 mEq/L, and potassium to 6.7 mEq/L. Because of this, peritoneal dialysis was instituted on June 11, 1964 with improvement in his general condition. On June 13, following the dialysis, his BUN was 109 mgm%, and the potassium 4.6 mEq/L.

He once again gradually deteriorated following this, and a second peritoneal dialysis was attempted on July 20, 1964, but was unsuccessful, apparently because of peritoneal adhesions. It was agreed by all concerned in his care that his life expectancy with continued medical treatment was limited to days or weeks at the most. It was therefore decided that he should receive a kidney transplant using his 34 year old mother as the kidney donor. A general evaluation and renal function studies on the mother showed her to be entirely normal. She was therefore accepted as a kidney donor.

On August 5, 1964, the mother's right kidney was removed and transplanted to the left lower quadrant of her son with anastamosis of the renal vessels to the left common iliac artery and vein and implantation of the ureter into the bladder. The renal ischemia time was 46 minutes. On the morning of operation, his BUN was 240 mgm% and serum creatinine 13.5 mgm%. He was started on azathioprine as immunosuppressive therapy on the day prior to transplantation in the dosage of 5 mgm/kgm body weight. This was continued on the day following transplantation.

During the first 24 hours following transplantation he put out 13 liters of urine; 30 hours after the transplant had been completed BUN was 6 mgm% and the serum creatinine 0.6 mgm%. Urine output decreased over the next week to about 2 liters a day and stabilized at about 1500 cc daily where it has remained until the present time. On the fourth postoperative day, the graft was re-explored because of pain and tenderness in the region of the graft and a temperature elevation to 103°F. A small hematoma was evacuated but no urine collection or evidence of sepsis was found.

Following exploration, he remained febrile and it was decided that this represented a very early threatened rejection of the transplant, although there was no impairment of its function. Therefore, in addition to the azathioprine he was given a single dose of actinomycin C, 10 mcg/kgm body weight intravenously, 150 rad of external radiation through anterior and posterior portals to the transplant only

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and was started on prednisone, 100 mgm daily by mouth. Following this therapy, he became afebrile and remained so. Throughout this time the function of the transplant remained normal. The prednisone was gradually tapered and discontinued on September 7, 1964, and he was then maintained on azathioprine alone for immunosuppression.

On the 47th post-operative day, he again had an episode of threatened rejection characterized by a temperature elevation to 101° F, pain and tenderness in the region of the graft and by enlargement of the graft. The graft also became quite hard to palpation. Prednisone therapy was instituted once again at this time in the dosage of 100 mgm daily. There was disappearance of all signs of impending rejection within 12 hours. His urinary sodium excretion transiently dropped to 30 mEq/day at the time of this rejection crisis but the BUN and the serum creatinine remained normal. The WBC was stable at 5-6000, and serum electrophoresis showed a normal pattern for gamma globulins.

He was discharged from the hospital on the 58th post-operative day with his wounds well healed and with normal function of his kidney transplant. Urinalysis was normal with a specific gravity of 1.023 and urine culture was negative at the time of discharge. Immunosuppressive medication at the time of discharge was azathioprine, 75 mgm by mouth daily and prednisone, 3 mgm by mouth daily. At the time of this writing, two and a half months have elapsed since his transplant was performed and he is doing well. He has gained 30 lb, is living at home and has returned to school. The function of the transplanted kidney remains normal with a creatinine clearance of 188 liters per day.

Discussion

The early success in the case described corresponds to experience reported by several other groups in this country and in Europe who have performed kidney homotransplants in man.[3,4,5,6] At present, this procedure is still on an experimental basis since the long term results of such transplants can be evaluated only after an adequate period of time has elapsed. Only patients in the end stage of renal failure, with a life expectancy measured in days or weeks at the most, are considered for this procedure.

Summary

The case report of the first renal homotransplant to be performed at the University of Kentucky Medical Center is presented. The transplanted kidney is continuing to function normally two and a half months post-operatively.

Addendum: This patient is continuing to do well, with normal function of his renal transplant, seven and one-half months following transplantation.

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SPECIAL ARTICLES

The Search for Individuality†

CALVIN PLIMPTON, M.D.*

Amherst, Mass.

IT IS traditional to recognize on these occasions that we are living in uncertain times, facing great hazards, and yet offered great opportunities and challenges. I will not belabor the point—you know as well as I that if all commencement speakers were laid end to end—well, it would be a very good thing!

First, I am proud and pleased to give the first Edwin Munich Memorial Lecture. I envy those of you who knew him, and can at least count myself fortunate to have met Mrs. Munich.

Now permit me a little of the purple prose. It wasn't so long ago that this school was only a happy gleam in the eye of Mr. A. B. Chandler; it then became the virgin bride of William Willard; and now, today, a full-fledged mother with a magnificent litter, if that is the right word. Fortunately, although the gestation requires four years, in some mysterious way, there will be a delivery every year! While a parent loves each of his children as impartially as possible, there is something exceedingly special about the first born. It is an honor to be here to salute the great first class of the University of Kentucky.

But platitude or not—our life is very confusing. At least it seems so to us, and I would like to explore one aspect of the confusion with you.

The aspect which interests me is how to find our individuality. And we have to find it before we can protect it, preserve it, or even bolster it. Such a discovery of our individuality is important to us as people, and to us as doctors. There are many interesting and opposing forces in our society today, each of which constitutes a jeopardy to the individual. On the one hand, society is swallowing us in its demand for conformity. This is reasonable, for at the speed of sound, no one wants a nomad at the controls of a jet liner. There is no opportunity for Brownian movement on the parkway.

On the other hand, much of the conformity comes not so much from external pressure, as from an internal fear of standing alone, a fear of being different—in short, a fear of being oneself. I know that the man who tries to think for himself is immediately drowned by the mass media, and mass advertising. I know that what little bit of individuality may still be respiring is shredded by a thousand different distractions, entertainments and diversions leading to a terminal fragmentation.

We cannot ignore these forces which jeopardize our individuality. We must rise above them. Many of us who started to use numbers—Social Security, bank, etc., numbers for greater efficiency—now like the protective anonymity of being a cypher or a statistic. If we are going to be individuals, we must rise above them and use them instead of being used by them.

There are going to be increasing uses of these numbers. Computers are here to stay. They should be used to free a man to be human. But an excessive dependence and trust in them can destroy what is human in us. We overlook and forget their weaknesses. Sometimes they behave with pure whimsy. There was, for instance, a machine for translating English and Russian. The phrase "The spirit is willing, but the flesh is weak" was fed into the machine. The resulting Russian translation was fed back into the machine and out came "The whisky is agreeable, but the meat is stale". (Or should I say bourbon in this part of the world?)

Machines and computers have more serious hazards. Sometimes they can come to the *right decision for the wrong reason.* This would disturb us in a man and upset our confidence in him. In the long run it would bother us with a computer. But sometimes the computer can come to the *wrong decision for the right reason.* The example I think of is the problem of deciding which of two chronometers would be most accurate. The computer worked on this twice a day, and noted that one clock seemed to lose about four seconds every 24 hours. The other clock was always exactly right. This one was recommended by the machine. The only difficulty was that the clock was broken, and indeed every twelve hours it was exactly right!

A computer should release a man to be a man and not to give his manhood away.

I have used these examples to illustrate the importance of the individual. But is this importance real? Is there more to this importance of an individual than

† *The First Edwin Munich Memorial Lecture delivered to the first graduating class of the University of Kentucky College of Medicine, Lexington, Ky., on May 18, 1964.*

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a delightful and consoling myth of hoping one is important, even when this is contradicted by the facts?

There is the hard core of belief and faith that the strength of society, the wisdom of a decision, and the success of an act depend on the individual. It is a man acting as an individual, and not as a large army, which has led to great advances. Some of these have been large cooperative efforts, but they have been the cooperation of individuals. They have been with the "consent of the governed", and the fact that the participants have retained their individuality, that their importance and dignity as individuals have been recognized, is the fact responsible for the appealing success of such endeavors.

It is my prejudice—or if you wish to dignify it, my belief—as an unemployed physician, and a sort of janitor at Amherst College—it is my belief that education has a very real role to play in finding, in capturing, in discovering, in developing individuality. It is *not* a matter of making the world safe for individuals—or preserving individuality. Preservation is a dreary process and what is preserved is usually dead. Too many men receive our respect for their potential to become individuals, rather than for any actual achievement. Too many people are only going through the motions.

In order for education to do something about such a discovery one needs a goal, a North Star, a vision. The example which comes most quickly to my mind is the medieval hod carriers on the road to Chartres. They were each asked what they were doing.

The first said, "I am carrying bricks."

The second said, "I am making a wall."

The third said, "I am building a cathedral."

The vision that I have of the cathedral of education follows. But first let me emphasize that I see no fundamental difference between a liberal arts education and medicine. Both are concerned with the pursuit of truth and the enlargement of understanding. One flows into the other. There is no gradient. There is a free diffusion.

Good education and good medicine have an ultimate concern in the total development of human beings so that each can become what he is capable of becoming. This means a fullness of development, not a roundness. It does not necessarily mean a more graceful, adjusted, compatible, decorative creature. It should mean a man who himself has a serious concern, and hence has some of the basic integrity we admire in all great men, be they successful or not. Education can assist in this process, for through education we increase the range of our activities and increase the intensity of our efforts. Education can stimulate the desire and capacity for work, as well as effectiveness. Education sharpens our sensitivities and improves our perceptions. The need for inquiry fuses with the act of learning so that scholarship and teaching, theory and practice become inextricably intertwined in a creative relationship.

Such education is more than training—even when the training is described as "teaching a man to think". I resist the goal of a trained surgeon, or trained internist, and would prefer to substitute an educated surgeon and an educated internist.

I agree that training can teach you how to do, and how to analyze. This is important. But education is more than that. Education is *not just listening*, it is *hearing*. It is not just *looking*, it is *seeing*. It is not just *doing*, it is *being*. Education recognizes that being alive is not living. And some of us will remember that divine as the ecstasy of being in love may be—being in love is still not loving. Education means being alive enough to learn—alive enough to be curious, and finally, alive enough to live and to love.

The relationship between what a man needs to know and a man needs to be is a subtle one. It is reflected in the breadth of one part of our curriculum, and the depth in another. It varies from man to man, and at different times varies within one man. We can teach him to know, but we can only help him to be, by stimulating and inspiring him to expend *his* efforts.

Again we emphasize the importance of the individual, and the relevance of *his choice*. This importance becomes the unifying philosophy which balances the uses of diversity and conformity, breadth and depth, education and training. Its success is reflected when the attitude of the student becomes more important than the subject matter, the pursuit of knowledge more important than its acquisition, and when the choices and kinds of effort elicited are celebrated above the resulting event. The validity of such attitudes rests on the validity of the individual.

The purposes of such development is not to provide a fuller life but to enable man to live, to move, and to make choices and decisions. With such education, decisions and choices become more profound and the need for decisions in areas of which we are currently unaware can be anticipated. Decisions susceptible to a quantitative analysis are relatively easy, but the most completion depends on an enlarged understanding and that quickened sensitivity which comes with an intimate contact with human experience in all its forms.

So much for the vision—how do we approach this goal? The crux is a personal involvement. We all went to college and to medical school because we *cared to learn*. Now we must turn this around—and begin to *learn to care*. There are some who think compassion is something one has or doesn't have. My teacher D. W. Atchley emphasizes that it is not killed by science. But I go further. We can learn to care. In colleges we learn to care for beauty—for truth. In medical school we also can learn to care. Remember that first time when the professor reminded you that putting your knee on the bed, or your foot on the frame might cause the patient real distress. Once was enough, for we learned to care, and never shook another patient's bed. The transforming powers of caring are immense. There are the changes which such personal involvement cause in us—and those which occur in the objects of our care. As Emily Dickinson said, "I was helped as if a kingdom cared".

This personal involvement is exceedingly powerful. After the Koran, the most authoritative text of Islam are the Hadith—Conversations with Muhammed. One of them states:

If something is wrong, correct it with your hand,
If you cannot, correct it with your head.
If not, correct it with your heart—but remember

this is the weakest.

I think this means that feeling about something is not enough. Thinking is still not enough. Personally doing something is the only answer.

Again comes the question, how does one get personally involved? The answer is very simple to say and very hard to practice. You simply ask questions. While I am a great supporter of the dumb question, which so frequently rocks the teacher back and forces him to reconsider all his assumptions, I do not mean to support the unprepared, the unstudied question. As soon as we begin to ask genuine questions, curious questions, a wonderful change takes place. But there is a warning. In school we all learn to *suspend belief*. We follow Socrates: "Only the examined life is worth living". We suspend belief while we examine. But I ask you to go a little apart, and learn to *suspend disbelief* until you have examined, until you have asked questions.

This is seen countless times in medicine. Over and over again, you have discovered that once you took a history, the man who previously seemed a repulsive degenerate now arouses your interest, and your compassion. Even with that absolute nadir described as "too dumb for a history, too fat for a physical", after a few questions, you find yourself compassionately helping to release that thin person who is struggling to escape from every fat one.

It means asking. It means temporarily suspending belief—and suspending disbelief. But only *you* can ask the questions.

We can teach students to answer questions. We can teach animals to solve problems, rats to run mazes, dogs to play pingpong, and even pigeons, I am told, to play poker. We can suggest to you *how* to ask questions, suggest *how* to take a history, *how* to do research, but only you can do it. It is sad, perhaps, that so important a process should be so lonely, and so personal,—and yet how typical. You are born alone, you die alone, and only for the brief period in between, you have the wonderful possibilities for not being alone. But even that depends on your initiative—depends on you as an individual—you must do it.

It seems very simple. It is. But most people never ask, never inquire, never live. Once they start, they cannot stop. But most never start.

This is your advantage. Medicine is the most fulfilling opportunity. A patient is there before you. He stimulates your questions better than almost anything else. No teaching machine ever could compete with a patient. But, remember, answers do not matter. They change from year to year. But the questions have not changed—not since the beginning of time. They do have to be rephrased or restated. If we want to pursue our Chartres cathedral, these questions must be asked by us.

I understand that in a moment of illumination, and it must have been a very great illumination indeed, Mae West said: "Too much of a good thing can be wonderful".

Well—I don't see how too much of this good thing —medicine—can ever be anything but wonderful.

Remember

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May 2-8

EDITORIALS

The Most Important Meeting

THE year 1965 is a crucial year for American medicine. It is a year in which important and far-reaching events are transpiring that may have a long-lasting impact on how we practice medicine in America.

An outstanding highlight in medicine in 1965 will be the 114th annual convention of the American Medical Association June 20-24 in New York City. It is our conservative estimate that more than 10 per cent of all American physicians, and perhaps as many as 15 per cent of those in private practice, will register for the New York convention.

Nowhere else in the entire world do physicians gather in such numbers to continue their medical education in an intensive short course that, literally, has something for everyone. Hundreds of scientific papers will be presented by the top medical scientists of our time, from foreign lands as well as our own country. Newest teaching films will be shown. Hundreds of scientists will offer exhibits in which the entire spectrum of medical progress in 1965 will be on view.

American physicians do not attend the AMA annual convention just to take a trip to New York, although that is an interesting sidelight. They attend because they have learned through the years that nowhere else can they find out so much about new developments in medical practice; where they can learn many things that will be of inestimable value to them in their own practices.

The Council on Postgraduate Programs of the AMA has done an outstanding job in preparing the scientific programs for the 114th annual convention. This is the single most important medical scientific meeting in the world this year.

On behalf of your professional society, the American Medical Association, I urge personally that every physician in America attend the June convention.

DONOVAN F. WARD, M.D.
President, AMA

Medical Libraries

THE President's Commission on Heart Disease, Cancer and Stroke recently released Volume I of "A National Program to Conquer Heart Disease, Cancer and Stroke". The report stated that medical libraries were of primary importance in the communication of information between scientists and practitioners. The report indicates that the nation's medical library system is grossly inadequate for the task, due to what is called a "serious imbalance of extramural support". It is pointed out that in 1964 the Public Health Service appropriations totaled over one billion dollars, but less than one million went to the support of medical libraries.

The Commission recommends: A — That two million dollars per year for a five year period be made available to the National Library of Medicine for intramural research and developmental activities to explore new technologies for more efficient management and dissemination of the world's bio-medical literature; B — That not less than $30 million per year for five years be authorized and appropriated to the National Library of Medicine for a program of grants and contracts to support improved medical library service in the United States—including facilities, resources, training of personnel, secondary publications, and library and communications research; C — That broadly conceived legislation be initiated clearly authorizing the National Li-

brary of Medicine to assist medical libraries in the ways recommended.

The National Library of Medicine is stated by the Commission to be the cornerstone of the national medical library network. It is said to have the world's largest collection of the published medical literature and to operate the largest computer-based information storage and retrieval system yet to be devised.

How the program of the Commission, if enacted, would affect the medical library system of Kentucky remains to be seen. The libraries of our two medical schools are at present our principal resources in this respect.

The Kornhauser Memorial Medical Library, University of Louisville and Jefferson County Medical Society, founded in 1837, has a collection of 61,500 books and periodicals. It takes about 1,200 different medical journals and adds almost 1,500 books annually. The Library has an excellent historical collection of 5,000 volumes printed before 1850, including special collections from the original Library. A new building is being planned for the Library which will house 125,000 volumes.

The Library provides information and teaching services to the faculty and students of the medical school, as well as the physicians of Louisville and surrounding areas. Bibliographies and free photocopies of needed articles are prepared and sent to practicing physicians. Two lists giving the Library's holdings, one arranged by title and one by subject, are available to any Library user.

The University of Kentucky Medical Center Library is in its eighth year of operation and has approximately 82,000 volumes. The current periodical subscriptions number approximately 1,580. The Colleges of Medicine, Dentistry and Nursing plus the University Hospital, are served from the Medical Center Library. An interlibrary loan service to libraries throughout the world is maintained and there is an excellent working relationship with the University of Louisville Medical Library.

The Library will serve all physicians, dentists and people engaged in the life sciences in Kentucky directly from their offices; however, if a physician is associated with a hospital or clinic that has a library it is suggested that the physician request loans through the hospital library.

Although some community hospitals have developed attractive and adequate libraries, the library is often neglected and poorly supported. If the community hospital library is conveniently located in the hospital, comfortably furnished, and adequately stocked with books and periodicals, it will make a significant contribution to excellent patient care within the hospital.

WALTER S. COE, M.D.

There is a Season—A Time to Change

THE Rural Kentucky Medical Scholarship Fund, since its inception in 1946, has extended assistance to a total of 258 individuals — all but 18 were graduated with an M.D. degree. Currently there are a total of 122 of these graduates serving in 75 of Kentucky's counties. Although there are still communities in rural Kentucky with inadequate medical personnel, they are becoming much less numerous. The deficit now by comparison is in the specialties — several of which are poorly represented in rural Kentucky even in some communities with Hill-Burton Hospitals.

Because of these facts, the Scholarship Trustees have begun a modest program of specialty training, initially allowing the recipient — limited to one annually — after internship to enter a residency in radiology, pathology, anesthesiology or EENT — later modified to opthalmology and ENT. More recently pediatrics and internal medicine were added to the program. The University of Pennsylvania initially advanced the idea that training of these latter two groups more nearly prepared a physician for a family type practice. He would, of course, engage in the specialty of pediatrics or internal medicine respectively, and probably direct the department in a community hospital, but at the same time see other minor illnesses.

The directors of the Scholarship program, after observing this specialty training, are inclined to allow a larger number, carefully selected in each instance, to engage in advanced study. The recipients of this specialty training are still excluded from practice in the larger medical centers of Kentucky which generally are abundantly supplied with physicians with special post-graduate discipline.

The Scholarship program, however, will not greatly deviate from its initial purpose of providing generalists training.

C. C. HOWARD, M.D., CHAIRMAN

ORGANIZATION SECTION

Immunization Week Set May 2-8 By Governor Breathitt

May 2-8 has been officially proclaimed as Immunization Week in Kentucky by Governor Edward T. Breathitt. In doing so, the Governor joined the Kentucky Medical Association and other state organizations in urging all Kentuckians to check the immunization needs of everyone. The KMA Committee on Public Health, which sponsors the program, has completed plans for its observance.

Ralph D. Lynn, M.D., Elkton, Committee chairman, is urging all KMA members and allied groups to take an active part in Immunization Week by displaying special posters promoting this annual drive and by checking patients' immunization status.

"Proper immunization," Doctor Lynn noted, "will provide our families with the protection needed from the dreaded diseases of diphtheria, tetanus, polio, pertussis, and small pox." He stressed that immunization must be a year-round program, and that not only school age children, but adults and pre-school age children as well, should avail themselves of the vaccines which afford protection against these death dealing diseases.

It was pointed out that proper immunization has resulted in Kentucky's not reporting a new case of poliomyelitis since 1963 when a vigorous vaccine campaign was conducted to eradicate the state of the killer and crippling disease.

Since Kentucky's Immunization Law was passed, a new, safe, and effective vaccine against measles, has been developed. The chairman added that contrary to public opinion, measles can be a serious disease, and he urged that parents also get their children properly immunized against this disease.

House of Delegates, Interim Talks Stress Health Care Legislation

More than 223 physicians, wives and guests attended the combined meeting of the KMA House of Delegates and Interim Meeting in Owensboro March 17 and 18.

Featured speakers for the House of Delegates meeting were Edward R. Annis, M.D., Miami, Florida; Congressman Durward G. Hall, Springfield, Missouri; and Congressman Tim Lee Carter, Tompkinsville, Kentucky.

These men gave a full picture of the developments in Washington relating to the many legislative proposals concerning health care for the aged. KMA officials were high in their praise of the presentations that were made.

Because the Interim meeting closed at the deadline for The Journal, it was not possible to include in this issue pictures taken at the meeting.

Two resolutions were passed at the special meeting. One was presented by the Board of Trustees urging the House Ways and Means Committee to hold public hearings on the total picture involving proposals for the health care for the aged. The second resolution, introduced by the Fayette County Medical Society, called for a full study of the legislative proposal growing out of the President's Commission on Heart Disease, Cancer and Stroke.

The Interim Meeting program the next day, featuring authorities from across the nation, generated much interest and a record number of questions were presented during the question and answer session.

This meeting featured the following speakers: Russell B. Carson, M.D., Ft. Lauderdale, Florida; Mr. Nathan J. Stark, Kansas City, Missouri; Mr. Robert E. Lee, Tucson, Arizona; Wesley W. Hall, M.D., Reno, Nevada; and Austin Smith, M.D., Washington, D.C.

The afternoon session of the Interim Meeting was devoted to legislative matters relating to Washington and Frankfort and was planned and presented by the Council on Legislative Activities. Speakers at this session were John C. Quertermous, M.D., Murray, chairman for National Affairs of the Council, and James C. Cantrill, M.D., Georgetown, chairman for State Affairs.

The KMA Board of Trustees held a day-long meeting on Wednesday and various committees scheduled meetings during the two-day period.

AMA Annual Meeting June 20-24 To Feature Best in Medicine

The latest and best in research and developments in medical science will be made available to American physicians June 20-24 when the American Medical Association meets in New York City for its 114th Annual Convention.

The scientific program, to be held at the New York Coliseum, will offer such features as: six general sessions dealing with adverse drug reactions, organ transplantation, hearing, and other subjects; 23 medical specialty programs including a new section on allergy; and over 700 scientific and industrial exhibits.

Special sessions on nuclear medicine, maxillofacial surgery, and nursing will also be presented. Lectures, panel discussions, motion pictures and color television are other highlights of the year's most extensive and up-to-date scientific program.

Delmas M. Clardy, M.D., Hopkinsville, KMA

president, has urged that all Kentucky physicians make early reservations for this, the most important medical meeting of the year. Further information on the program and activities of the convention, which will have its headquarters at the Americana Hotel, will be carried in later issues of The Journal. An advance registration form may be found on page 302 of this issue.

KMA Plans Outstanding Program For 1965 Annual Meeting

An intensive and varied program of postgraduate education is being planned for Kentucky physicians attending the 1965 KMA Annual Meeting to be held September 21-23 at Louisville, Delmas M. Clardy, M.D., Hopkinsville, KMA president and chairman of the Council on Scientific Assembly, has announced.

The Scientific Program Committee, under the chairmanship of Douglas M. Haynes, M.D., Louisville, have met and are arranging a comprehensive and interesting program including the latest in medical research and information, Doctor Clardy reported.

For the second year, the scientific general and specialty sessions will be held in the spacious, air-conditioned Convention Center in Louisville, considered by many to offer the best meeting facilities in the area. Once again, the Kentucky Hotel, a block from the Center, will serve as headquarters for the meeting.

Most of the guest speakers, authorities in their specialty fields of medicine, have already accepted invitations to appear on the scientific program. Information on these speakers and other highlights of the meeting will be presented in subsequent issues of The Journal.

Medical alumni of the University of Louisville classes of 1915, 1920, 1925, 1930, 1935, 1940, 1945, 1950, 1955, and 1960 will be holding class reunions this year. The alumni will hold their reunions again in 1965 on the Belle of Louisville, one of America's few remaining sternwheelers.

Drs. Moore, Eschbach, to Speak At KAGP Meeting May 5-7

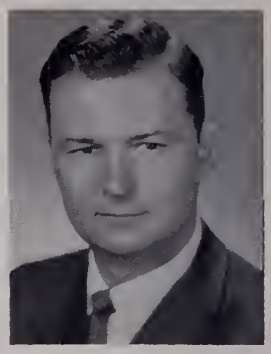
Joseph Eschbach, M.D., Seattle, Wash., and George E. Moore, M.D., Ph.D., Buffalo, N.Y., will be among the ten distinguished guest speakers scheduled to appear at the May 5-7 annual meeting of the Kentucky Academy of General Practice at the Kentucky Hotel, Louisville, according to William P. VonderHaar, M.D., Louisville, program chairman.

Doctor Moore, director of Roswell Park Memorial Institute at Buffalo, will deliver two addresses before the Academy on Thursday, May 6. His topics are: "Recent Advances in Cancer Research" and "Lung Cancer and Tobacco."

Doctor Eschbach, who is assistant in medicine and director of the Home Dialysis Program of the University of Washington School of Medicine, will also speak on Thursday on the subjects: "Management of Chronic Uremia by Hemodialysis" and "Recognition and Management of Acute Renal Failure."



Doctor Moore



Doctor Eschbach

Wednesday speakers and their topics are: Robert L. Egan, M.D., Emory University, Atlanta—"Mammography in the Diagnosis of Breast Disease;" Alfred L. Allman, M.D., Atlanta—topic to be announced; and Theodore N. Guiglia, M.D., University of Kentucky Medical Center — "Diagnostic Problems in Thyroid Diseases."

Sheldon G. Sheps, M.D., Mayo Clinic, Rochester, Minn., will speak on "The Differential Diagnosis of Chronic Ulcers of the Leg" and "Management of Hypertension Associated with Renal Artery Disease" on Thursday.

Thursday's program will also include talks by Neil W. Swinton, M.D., Lahey Clinic, Boston, and John W. Yarbro, M.D., University of Minnesota School of Medicine, who will both appear also on Friday. Doctor Swinton will discuss "Ano-Rectal Surgery" and "Polyps and Cancer of the Rectum and Rectosigmoid." Doctor Yarbro's subjects will be "Recent Developments in the Chemotherapy of Cancer" and "Starvation Therapy of Extreme Obesity."

Thomas P. Kearns, M.D., Mayo Clinic, will also present papers on Friday, May 7. His topics will be: "The Ocular Aspects of Cranial Arteritis" and "Motor Anomalies of the Eye of General and Neurological Interest." Doctors Kearns and Yarbro are both graduates of the University of Louisville School of Medicine.

Doctors Moore and Swinton are being presented in cooperation with the Kentucky Cancer Society, Doctor Vonderhaar said.

KMA Announces 11 New Members

The membership records of the Kentucky Medical Association showed the addition of 11 new members as of March 10. Among them, from Lexington, are the following: Charles H. Nicholson, M.D., L. Charles Allen, M.D., and Leonidas Mostowycz, M.D.

Other new members are: Alvin D. Poweleit, M.D., Covington; Max Jones, M.D. and Harvey A. Page, M.D., both of Pikeville; Thomas F. Plaut, M.D. and John E. Engle, M.D., both of Whitesburg. Also listed are: Frank Varney, M.D., Stone; and Thomas D. Pruitt, M.D. and Paul M. Walstad, M.D., both of Harlan.

Recommended Dosage of Lomotil Liquid to Control Diarrhea

File: Diarrhea

LOMOTIL®

Age	INITIAL LOMOTIL LIQUID DOSAGE*
3-6 mo.	½ tsp. t.i.d. (3 mg.)
6-12 mo.	½ tsp. q.i.d. (4 mg.)
1-2 yr.	½ tsp. 5 times daily (5 mg.)
2-5 yr.	1 tsp. t.i.d. (6 mg.)
5-8 yr.	1 tsp. q.i.d. (8 mg.)
8-12 yr.	1 tsp. 5 times daily (10 mg.)
Adult	2 tsp. 5 times daily (20 mg.) (or 2 tablets q.i.d.)

*Based on 4 cc. per average teaspoonful.
Note: After diarrhea is controlled the initial dosage can usually be reduced to meet the requirements of the individual patient.

LOMOTIL® TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

Precautions
Lomotil is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Cautions and Side Effects
Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*

Dr. Samp to be Guest Speaker On Ky. Surgical Program

Robert J. Samp, M.D., assistant professor of surgery and director of the division of clinical oncology at the University of Wisconsin Medical Center, will be the featured guest speaker at the May 14-15 meeting of the Kentucky Surgical Society in Louisville.



Doctor Samp

This year's meeting, being held in cooperation with the department of surgery at the University of Louisville School of Medicine, will have its headquarters at the Brown Hotel. Rudolf J. Noer, M.D., chairman of the department of surgery at the University of Louisville, will be in charge of the all-day program on Friday May 14, at Louisville General Hospital.

Doctor Samp, whose address, entitled "Some Considerations on the Cause and Treatment of Coli-Rectal Cancer," will be presented during the Saturday morning session, received his M.D. degree from the University of Wisconsin. He is clinical cancer coordinator for the affiliated hospitals of that school and medical consultant for the Wisconsin division of the American Cancer Society.

Papers to be delivered on Friday include the following, listed with their authors: "Emergency Transportation and Care for the Critically Injured"—James C. Drye, M.D. "Use of the Piston Respirator in the Treatment of Flail Chest"—Herbert T. Ransdell, M.D.; "Diagnosis and Management of Hiatus Hernia" —John Harter, M.D.; and "Acute Renal Failure: A Preventable Disease"—Mohammad Atik, M.D.

Also on Friday's program are: "Prophylactic and Reconstructive Surgery of Rheumatoid Arthritis of the Hand"—Harold E. Kleinert, M.D.; "Foreign Bodies in the Bronchi of Children" — Charles K. Sergeant, M.D., and William Johnson, M.D.; and "Temperatures in Local Infections" — Norton G. Waterman, M.D. All the speakers listed for the Friday session are members of the staff of the U. of L. department of surgery.

Saturday's program includes the following addresses and speakers: "Diverticulitis"—William T. Rumage, Jr., M.D., Louisville; "Ulcerogenesis after Roux-en-Y Choledochocystojejunostomy." — George B. Sanders, M.D., Louisville; "Clinical Syndromes Associated with Occlusive Disease of the Subclavian Artery in 14 Patients"— Lester R. Bryant, M.D., and Frank C. Spencer, M.D., Lexington.

Also appearing on Saturday's program will be: "Surgical Rehabilitation of the Gastric Cripple"— Howard Dorton, M.D., Lexington; "Cancer and the Gentle Truth"—Malcom J. Thompson, M.D., Louisville. Charles E. Tucker, executive vice-president of the Kentucky division of the American Cancer Society, will speak on "Hope Ship" during the Saturday session.

Drs. Pennington, Quertermous Speak at Hospital Meetings

Robert Pennington, M.D., London, chairman of the KMA Board of Trustees, addressed a meeting of the Cumberland Hospital Conference held March 11 at Boone Tavern, Berea.

John C. Quertermous, M.D., Murray, chairman for National Affairs of the KMA Council on Legislative Activities, was the featured speaker at the March 5 meeting of the Twin Lakes Conference at Cadiz. Both physicians discussed current legislative matters relating to health care for the aged.

The Cumberland Conference is composed of 32 hospitals in a 34-county area. The Twin Lakes Conference is made up of 33 member hospitals in 36 counties. They are two of the four Conferences in the state.

G. L. Armstrong is New Director Of KMA Field Service Office

Gilbert L. Armstrong, Louisville, became new director of Field Services for KMA on March 15, replacing W. Kenneth Young, who resigned after serving the Association since August, 1964.



Mr. Armstrong

Mr. Armstrong, a native of Laurelville, Ohio, had worked with Allied/Egry Business Systems for 17 years prior to joining the KMA staff. Before that time he was employed by Eastern Airlines following his graduation from Ohio Wesleyan University.

A resident of Louisville since 1948 (also from 1937 to 1939), Mr. Armstrong has been active in community civic and church affairs. He is a deacon in the Presbyterian church, a former secretary of the Kiwanis Club, and a Mason. For several years he participated in Little League and Babe Ruth League team activities, serving two years as a team manager, and has worked with Boy Scouts.

Mr. Young has accepted a position as district sales representative for American Breeders Service, Chicago, and will have his office at Fort Wayne, Ind., covering the territory of Northern Indiana, Ohio, and Michigan.

Economic Security Head Resigns

Mr. Earl Powell, Kentucky's Commissioner of Economic Security for many years, resigned late in February to accept a position with the Central Investors Life Insurance Company at Lexington, it was announced. Mr. C. L. Dawson, Louisville, was appointed to take the post of Commissioner.

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A Solfoton tablet or capsule at six hour intervals maintains sedation at the threshold of calmness. Usually the patient is not conscious of sedation; only conscious of feeling better. Safe for continuous use.

Each tablet or capsule contains: Phenobarbital, 16 mg. Warning: may be habit-forming. *Bensulfoid, 65 mg. Contra-indications: same as those of 16 mg. phenobarbital.

Dispensed in bottles of 100 and 500 tablets or capsules

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See white section, P.D.R.

Medical Assistants Meeting Set May 14-16 in Louisville

The Kentucky State Association of Medical Assistants will hold its 1965 annual meeting May 14-16 at the Kentucky Hotel in Louisville, according to Miss Dorothy Downs, Louisville, KSAMA president.



Miss Downs

Mrs. Wanda Taylor, Louisville, president-elect of the association, will be installed Sunday, May 16, at the State Luncheon, with other officers to be elected that morning.

The convention will begin Friday evening, May 14 with a leadership seminar conducted by a representative of the American Association of Medical Assistants, and will continue on Saturday morning. The educational session on Saturday afternoon will be followed by a banquet.

A breakfast and reception in honor of Mrs. Taylor will be held on Sunday morning, followed by the business meeting and election.

Highlights of the meeting will include speeches at Saturday's dinner and the Sunday luncheon by well-known Louisville physicians, Miss Downs said. She pointed out that a highly instructive and interesting program has been planned, and urged the attendance of all members.

Kentuckians Hear Dr. Annis During Louisville Visit

Edward R. Annis, M.D., immediate past president of the American Medical Association, in Louisville to address the Founder's Day banquet of the Transylvania Medical Society, utilized his two-day stay in the city to address a number of medical groups, and by television, the citizens of the state.

Doctor Annis, who arrived in Louisville on March 11, spoke that evening to an audience of approximately 225 physicians and their guests at the Founder's Day dinner held at the Executive Inn. An audience which included a number of prominent laymen heard him discuss the serious problems now facing medicine as a result of current health care legislative proposals.

On Friday evening, March 12, Doctor Annis engaged in a televised debate with Sam Ezelle, secretary of the AFL-CIO in Kentucky, on the same general topic. The former AMA chief expressed his views that federally-subsidized health care should benefit only those persons who needed such assistance.

Earlier on Friday, Doctor Annis and Robert C. Long, M.D., AMA trustee from Louisville, his official host, spoke before a meeting of the Board of Trustees of the Kentucky Hospital Association, which was holding its annual meeting in Louisville that week.

In other appearances during his stay in Louisville, the former AMA executive addressed separate convocations of the faculty and the students of the University of Louisville School of Medicine, and met with Dean Donn L. Smith of U. of L. Medical School and the medical council of the University.

Doctor Annis also held a news conference, appeared on "Small Talk," Phyllis Knight's daily current-events program on WHAS television, and taped a 30-minute television program for showing on WAVE the following Tuesday evening. A dinner party in Doctor Annis' honor given by Doctor and Mrs. Long concluded his visit.

Dr. Rainey Selected by Jaycees As "Outstanding Young Man"

Fred C. Rainey, M.D., Elizabethtown general practitioner, was recognized February 20 by the Kentucky Junior Chamber of Commerce as one of its three 'Outstanding Young Men for 1964' at a banquet held during the Jaycees' Winter Board Meeting in Frankfort.



Doctor Rainey

Doctor Rainey, former KMA Legislative Key Man for the Fourth Congressional District, was president of the Kentucky Jaycees in 1963-64 and is now serving as vice-president of the U.S. Junior Chamber in charge of Governmental Affairs. He is current chairman of the Hardin County Board of Health.

The 'Outstanding Young Men' are chosen each year by the Jaycees from candidates whose achievements have been significant to their professions and to the general welfare of the public.

KMA Diabetes Detection Program Sets Records for 1964 Tests

The 1964 KMA Diabetes Detection Program shattered all previous records in the number of tests reported and number diagnosed as new diabetics. This 14th Annual Drive, sponsored by the KMA in cooperation with the American Diabetes Association, saw 103,248 free tests made and 230 proven cases reported.

Since the first drive in 1951, more than 2000 previously unknown diabetics have been found. Although a new high was established this year, Robert S. Tillett, M.D., Louisville, 1964 Chairman of the KMA Diabetes Committee, said the continuing increase in the number of people with diabetes, known and unknown, makes it urgent that we learn more and more about the effectiveness of our educational and detection drive.

Doctor Tillett expressed his appreciation to all members of the county medical societies, allied groups, cooperating agencies, and news media for their participation in making this year's Drive such a success.

in maintenance therapy... a working analgesic for the active arthritic

ARTHRALGEN®

Each tablet contains:

Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.

a working analgesic for the active arthritic

—rapidly relieves early morning stiffness and arthritic pain. It promises a quicker response in most patients because its analgesic ingredients need no metabolic conversion before they act. As a combination of two prominent analgesic drugs, Arthralgen can often establish smoother, more complete pain relief because it synergistically produces more efficient analgesia on lower dosage levels of each.

two proven pain relievers

Arthralgen combines two better-tolerated, time-tested analgesics, acetaminophen and salicylamide, into a pharmacologically sound and therapeutically effective formulation. As Arthralgen, it penetrates tissues promptly and relieves pain rapidly with less likelihood of gastric irritation than aspirin.

sodium-free

Arthralgen contains no sodium. Therefore, it is often a safer and more suitable analgesic for use in the long-term treatments of arthritic patients who have other conditions which require sodium restriction.[1]

ARTHRALGEN®-PR (Arthralgen with prednisone)

Each tablet contains:

Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.
Prednisone	1 mg.

To help provide dosage flexibility in patients who require steroids, the basic Arthralgen formula is also available combined with prednisone as Arthralgen-PR. Prednisone is favored as the more advantageous steroid for use in Arthralgen-PR because it shows less tendency toward sodium retention, potassium excretion, and steroid-induced hypertension than that which often accompanies the use of cortisone and ACTH.[2]

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BRIEF SUMMARY

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

DOSAGE: One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis; nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

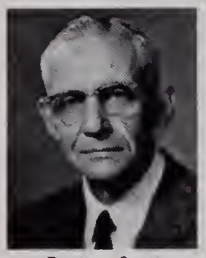
Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953. 2. Cohen, et al.: J.A.M.A., 165:225, 1957.

SE Section, American Urologists, Install Dr. Scott President

Douglas E. Scott, M.D., Lexington, was installed as president of the Southeastern Section of the American Urological Association March 17 at Miami Beach, where the section of the AUA held its annual meeting at the Deauville Hotel.



Doctor Scott

Doctor Scott, immediate past chairman of the KMA Board of Trustees, currently serving as trustee from the Tenth District, is a past president of the Fayette County Medical Society. He was treasurer of the Urological group for two years prior to his selection as president-elect last year.

Louis Roberts, M.D., Durham, N. C., was named president-elect at the Miami Beach meeting and will take office next year at the meeting in Memphis.

Dr. Clardy Discusses Socialism At First District Meeting

Delmas M. Clardy, M.D., KMA president from Hopkinsville, chose as his topic "The Key to Socialism" for his address before the joint meeting of the First Trustee District and the McCracken County Medical Society January 27 at Paducah.

Doctor Clardy gave a brief review of recent political history, and traced the origin of the Social Security System. In this light, he also discussed the advisability of attaching a health care bill to the Social Security program.

Following Doctor Clardy's presentation, a discussion session was led by John C. Quertermous, M.D., Murray, chairman for National Affairs of KMA's Council on Legislative Activities. Doctor Quertermous urged support of the Eldercare program, AMA's counter-proposal to Medicare.

The McCracken County Medical Society hosted the meeting, held at Boswell's Restaurant. O. Leon Higdon, M.D., Paducah, First District Trustee, presided. Attending were members from the following counties, which make up the First District: Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Marshall, McCracken, and Livingston.

Sixth District Key Man Meeting Stresses Medical Legislation

Pending National Medical Legislation was the topic of discussion at the Sixth Congressional District Legislative Key Men and KEMPAC meeting, which was held at the Imperial House in Lexington, Sunday, February 28, 1965.

Acting chairmen, J. C. Cantrill, M.D., Georgetown, and David Stevens, M.D., Lexington, told the group that the meeting was called for the following three purposes:

(1) promotion of the Eldercare bill, H. R. 3727;
(2) to develop a better organization in the Sixth District for KEMPAC; and
(3) to develop and implement the Key Man system.

It was taken by common consent of those present that all three objectives would be accomplished through harder work on the part of the county societies and the auxiliary. It was also pointed out that the Kentucky Medical Association headquarters is available to give much assistance.

The American Medical Association film, "Are 200,000 Doctors Wrong?", which is being used across the nation to promote H. R. 3727, the Herlong-Curtis Eldercare bill, was shown to the group and was enthusiastically received.

Dr. Long Testifies in Congress

Robert C. Long, M.D., Louisville, a member of the American Medical Association Board of Trustees, appeared with James Z. Appel, M.D., Lancaster, Pa., AMA president, to present the views of the AMA on four pending health bills before the House Interstate and Foreign Commerce Committee on March 4.

The two AMA officers discussed the Association's views on health-oriented bills for: construction of research facilities, Federal grants for professional and technical personnel for community mental health centers, extending the programs of the Vaccination Assistance Act, financial assistance for construction and equipping facilities for group practice of medicine and dentistry, and other attending provisions of the four proposals.



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position: Each tablet contains chlorthalidone, g., and reserpine, 0.25 mg.

raindications: History of mental depression, y rsensitivity, and most cases of severe renal patic diseases.

ing: Discontinue 2 weeks before general thesia, 1 week before electroshock therapy, f depression or peptic ulcer occurs.

autions: Reduce dosage of concomitant antiy rtensive agents by one-half. Discontinue if UN rises or liver dysfunction is aggravated. rolyte imbalance and potassium depletion occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.

Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.

For full details, see the complete prescribing information.

Average Dosage: One tablet daily with breakfast.

Availability: Bottles of 100 and 1000 tablets.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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when a change in environment overwhelms him with anxiety

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ide effects and precautians: The transitory rowsiness which may occur with hydraxyzine ICl usually disappears spontaneously in a few ays with continued therapy, or is carrectable y dasage reduction. Dryness of the mouth may e seen with higher doses. Involuntary motor ctivity has been reported in hospitalized atients on higher than recommended doses. lydroxyzine HCl may potentiate CNS depres- ants, narcotics such as meperidine, barbitu- ates, and anticoagulants. In canjunctive use, osage for these drugs shauld be decreased. ecause drowsiness may occur, patients should e cautioned against driving a car or operat- g dangerous machinery. **Parenteral Salution recautians and cantraindicatians:** This dosage orm is intended only far I.M. or I.V. adminis- ation and should not, under any circum- ances, be injected subcutaneously or intra- terially. When the usual precautions for I.M. jectian have been followed, reports af soft ssue reactians have been rare. I.V. adminis- ation shauld be slow, no faster than 25 mg. er minute, and should not exceed 100 mg. in ny single dose. Particular care shauld be used insure injectian only into intact veins; a few stances of digital gangrene occurring distal the injection site have been attributed to advertent intraarterial injection or periarte- al extravasatian, both of which should be oided. **More detailed prafessianal infarma- n available an request.**

Dr. Clardy Speaks at Meeting Of Thirteenth District

The Thirteenth Trustee District, meeting April 6 in Ashland, heard Delmas M. Clardy, M.D., Hopkinsville, KMA president, speak on "The Key to Socialism," according to Walter L. Cawood, M.D., Ashland Thirteenth District trustee, who presided at the meeting.

Doctor Clardy reviewed recent political history, and traced the beginnings of the Social Security System from the depression through the Roosevelt administration. In this connection, he discussed the current administration's proposed legislation for attaching medical care for the aged to the Social Security program.

After Doctor Clardy's talk, a discussion session was led by John C. Quertermous, M.D., Murray, chairman for National Affairs of the KMA Council on Legislative Activities. Doctor Quertermous urged support of the Eldercare program, AMA's counter-proposal to Medicare.

The Boyd County Medical Society hosted the meeting, held at the Henry Clay Hotel. Attending were physicians from Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan and Rowan Counties, which make up the Thirteenth District.

Occupational Health Conference Focuses on Responsibility

Industry must be encouraged to help solve the growing health problems caused by increasingly complicated industrial processes, according to key speakers appearing at the Governor's First Occupational Health and Industrial Hygiene Conference at the Campbell House, Lexington, March 9 and 10.

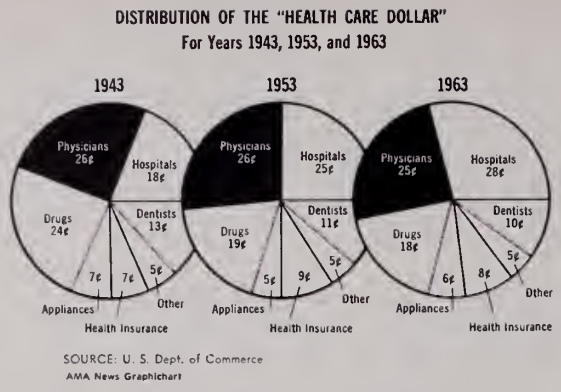
Industry and government should act in cooperation to develop solutions not only for the hazards involved in factory work, but the growing threat of polution of air, water and soil that has arisen in connection with modern industrial technology.

Governor Edward T. Breathitt was a featured speaker on the program. Robert A. Kehoe, M.D., director of the Kettering Laboratory at the University of Cincinnati also spoke. The Kentucky Medical Association and the Kentucky Industrial Medical Association co-sponsored the Conference.

Two Students Win Fellowships

Two junior medical students, one at the University of Louisville, and the other a Kentucky native at Johns Hopkins, are among 28 junior and senior medical students in the U.S. receiving Foreign Fellowships for experience in underdeveloped countries.

Phillips Lynn Sheffey, a U. of L. student from California, will spend ten weeks this summer at Pfeiffer Memorial Hospital in La Paz, Bolivia. Bradley Moreland Rodgers of Louisville, a student at Johns Hopkins, will go to the American Baptist Mission Hospital in Nellore, India. The fellowships, announced by the Association of American Medical Colleges, are made possible by a grant from Smith Kline and French Laboratories.



According to figures from the U.S. Department of Commerce, 28 cents of every health care dollar spent in 1963 went to hospitals, 25 cents to doctors, 18 cents for drugs, 10 cents was paid to dentists, 8 cents for health insurance, 6 cents for appliances and 5 cents for all other services. The above graph shows the changes in distribution of the health care dollar from 1943 to 1963.

Americans Spend More on Tobacco Than on Physicians' Services

Americans in 1963 spent $8.1 billion on tobacco, and $5.9 billion on physicians' services, out of a total of $375 billion spent for their personal needs, according to an analysis of that year's statistics by the American Medical Association's Department of Medical Economics.

Eleven billion dollars of the total went for liquor, the report stated. Of the total personal consumption expenditures in 1963, $167.5 billion was spent on nondurable commodities, $52 billion on durable commodities, and $155.3 billion for services, including the $5.9 billion for physicians' services.

Other health care figures for 1963 show that the nation's consumers spent $6.6 billion for hospital charges, and $4.3 billion for drugs. The figures are based on a report of personal expenditures from the U.S. Department of Commerce.

MEDICAL SCHOOL NEWS

Child Psychiatry Research Unit Planned for U.L. Med School

Construction will begin soon on a $228,514 child psychiatry research center at the University of Louisville School of Medicine, Donn L. Smith, M.D., Dean of the school, announced early last month.

The center, the first of three structures planned for a Children's Mental Health Center at U. of L., M.D. Lovick C. Miller, Ph.D., associate professor of will be operated under the auspices of the department of psychiatry, headed by William K. Keller, psychiatry, will direct the center.

Planned for later construction are a building for the Child Guidance Clinic, now at 206 E. Chestnut, and an inpatient building for children with more serious emotional disturbances.

Gifts and Grants Total $585,909

The Board of Trustees of the University of Louisville in its meeting March 17 announced that the School of Medicine was the beneficiary of $585,909 in grants and gifts recently awarded. Following is a list of the grants and their individual recipients:

From the U.S. Public Health Service—$51,840 to William K. Keller, M.D.; $33,073 to Felix Bronner, M.D.; $18,000 to H. C. Pirkle, M.D.; $15,950 to Joseph Gennaro, M.D.; $14,520 to Marvin Murray, M.D.; and $11,000 to Ephraim Roseman, M.D.

MEND, $13,000 to Hobart Belknap, M.D., National Dairy Association, $10,010 to Felix Bronner, M.D.; the Borden Company, $5,500 to Billy Andrews, M.D.; Mead Johnson Company, $4,450 to Leonard Reisman, M.D.; Geigy Laboratories, $3,866 to John F. Ice, M.D.; Ayerst Laboratories, $3,000 to Laman A. Gray, M.D.; and Westwood Pharmaceuticals, $2,000 to A. B. Loveman, M.D.

In addition, the Simpson County Heart Association gave $600 to the School of Medicine for research and education.

Faculty Appointments and Promotions

The Board of Trustees on March 17 also announced the following appointments, promotions and changes in faculty positions at the School of Medicine:

Joan R. Hale, M.D., John D. Hummel, M.D., William H. Baker, M.D., and Harold Q. Davis, M.D., all named clinical instructors in radiology. Leonard E. Reisman, M.D., named clinical associate in pathology; and William J. Martin, M.D., change from professor and chief of section on proctology to professor emeritus of proctology.

Promotions: William H. McBeath, M.D., to clinical instructor in community health; Thomas S. Wallace, M.D., to assistant clinical professor of community health; Charles K. Sergeant, M.D., to assistant professor of surgery; Marvin A. Lucas, M.D., to chief of section on proctology and Hoyt D. Gardner, M.D., to assistant clinical professor of surgery.

Additional promotions: Clarence E. Claugus, M.D., Samuel D. Weakley, M.D., Henry S. Collier, M.D., McHenry S. Brewer, M.D., and Edward Warrick, Jr., M.D., to assistant clinical professors of surgery.

Oscar A. Candia, M.D., was named temporary assistant professor of ophthalmology, and Richard E. Stafford, M.D., was named temporary research assistant professor of pediatrics.

Contact Lens Course Set May 13

The second session of a two-part postgraduate contact lens course, sponsored by the University of Louisville School of Medicine's department of ophthalmology, will be held from 9 a.m. to 5 p.m. May 13, according to Roderick Macdonald, Jr., M.D., associate professor of ophthalmology and director of the course.

Speakers for the May 13 session will be Chester Black, M.D., Indiana University School of Medicine, and Walter R. Morris, M.D., Louisville.

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

APRIL

14, 21, 28	Fourth Semiannual Postgraduate Course in "Psychiatry for Practicing Physicians," U of L School of Medicine, course to be held at the Louisville Area Mental Health Center, 2:00-6:00 p.m., Louisville.
15	Symposium on "Rheumatic Diseases," Rankin Amphitheatre, Louisville General Hospital, Louisville
21	24th Annual Samuel D. Gross Lecture, Rankin Amphitheatre, Louisville General Hospital, 12:00 Noon. Alvan R. Feinstein, M.D., Yale University, Guest Lecturer.
22-23	Kentucky Thoracic Society, Phoenix Hotel and the University of Kentucky Medical Center, Lexington
30	"Cardiology Night," Section of Cardiology, Department of Medicine, U of K Medical Center, 7:30-9:30 p.m., Lexington

MAY

5-7	KAGP 14th Annual Scientific Assembly, Kentucky Hotel, Louisville
5, 12, 19	Fourth Semiannual Postgraduate Course in "Psychiatry for Practicing Physicians," U of L School of Medicine, course to be held at the Louisville Area Mental Health Center, 2:00-6:00 p.m., Louisville
6	"Professors' Day," 9:00 a.m. to 3:00 p.m., U of K Medical Center, Lexington
13	Contact Lens Course, Department of Ophthalmology, University of Louisville School of Medicine
13	Pediatrics, "Refresher Course," 8:00 a.m. to 5:00 p.m., U of K Medical Center, Lexington
20	University Surgery Day, 12:00 noon to 5:00 p.m., University of Kentucky Medical Center, Lexington
28	"Cardiology Night," 7:30 p.m. to 9:00 p.m., U of K Medical Center, Lexington

IN SURROUNDING STATES

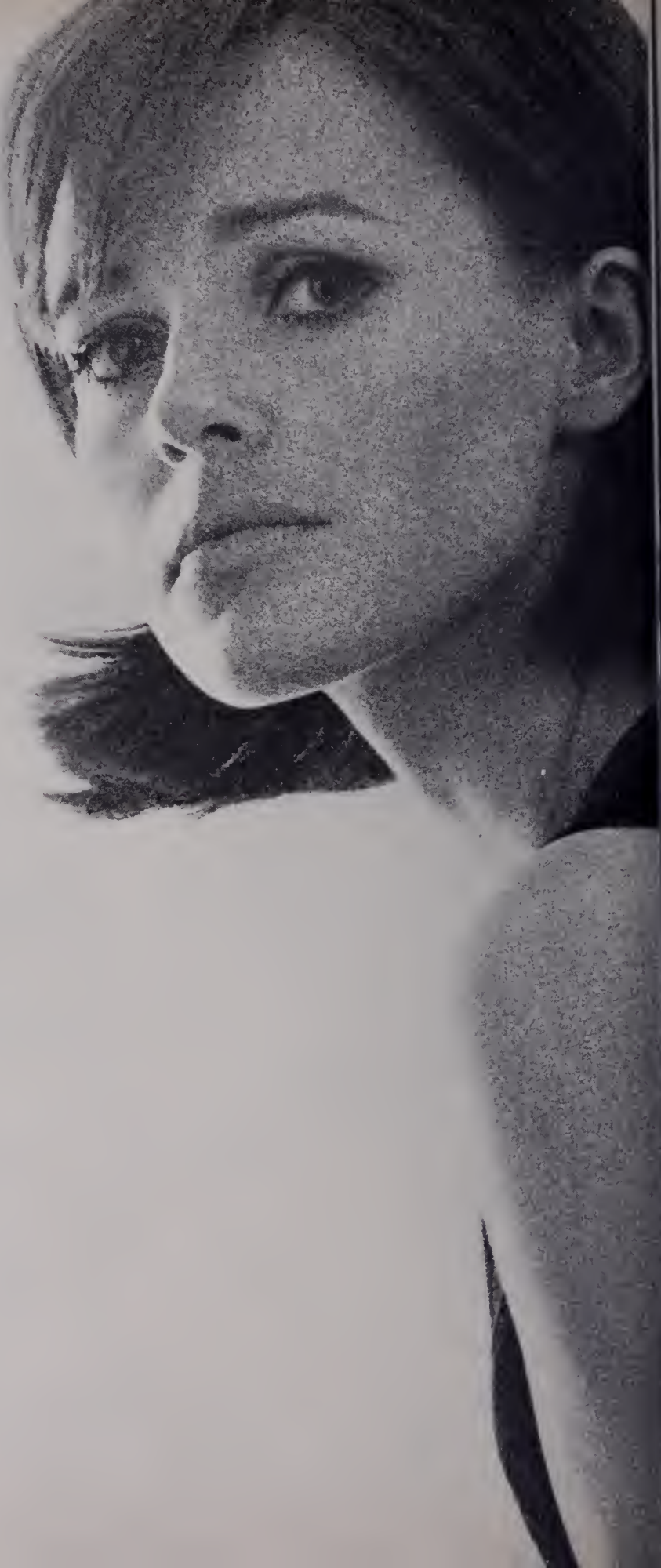
APRIL

15, 22	Postgraduate Course on Clinical Electrocardiographic Interpretation, Hahnemann Medical College & Hospital, Philadelphia
9-15	American Academy of General Practice, San Francisco
11-14	Tennessee Medical Association, Read House, Chattanooga
14	Society for Adolescent Psychiatry, New York Academy of Sciences, New York
22-24	Medical Association of State of Alabama, Annual Meeting, Birmingham
22-24	Symposium on "Clinical Gastroenterology," Mound Park Hospital Foundation, Inc., St. Petersburg, Florida
25-29	International Congress of Surgeons (North American Federation), Las Vegas
26-27	Congress on Environmental Health Problems, The Drake, Chicago
26-29	American Academy of Pediatrics Spring Session, Americana Hotel, Bal Harbour, Florida
26-29	14th Hahnemann Symposium on Mechanisms & Therapy of Cardiac Arrhythmias, Sheraton Hotel, Philadelphia
26-30	American College of Physicians, Postgraduate Course No. 13, Cardiopulmonary Diseases, University of Colorado Medical Center, Denver
26-May 1	American Academy of Neurology, Sheraton Cleveland Hotel, Cleveland
30-May 3	American Psychoanalytic Association, Commodore Hotel, New York

MAY

3-7	American Psychiatric Association, New York
4-5	Association of American Physicians, Hadden Hall, Atlantic City, New Jersey
9-13	American Urological Association, Roosevelt Hotel, New Orleans
9-14	Ohio State Medical Association, Annual Meeting, Columbus
10	Southwestern Surgical Congress, Velda Rose Hotel, Hot Springs, Arkansas
27-29	American Ophthalmological Society, Homestead Hotel, Hot Springs, Virginia
30-June 2	American Thoracic Society, Palmer House, Chicago

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Ski Club Being Organized

A group of Kentucky physicians with a keen interest in skiing and a lack of good ski areas nearby, are forming a club for the purpose of chartering a plane to Denver during the Christmas holidays to take advantage of Colorado's slopes.

In order to obtain the least expensive rates for such a trip, a club must be chartered and dues collected six months prior to the trip,. Any physician interested should contact L. S. Gettes, M. D., Dept. of Medicine, University of Kentucky Medical Center, Lexington, Ky., 40506.

In Memoriam

JOSEPH BRYANT HELM, M.D.
Smiths Grove, Ky.
1895 - 1965

Joseph B. Helm, M.D., 69, died February 27 at his home in Smiths Grove. He formerly was mayor of Smiths Grove. Doctor Helm, a general practitioner, was a 1917 graduate of the Medical Department of the University of Louisville and served as a lieutenant commander in the Navy in World War I.

ROBERT CARLISLE MOSS, M.D.
Bowling Green, Ky.
1887 - 1965

Robert C. Moss, M.D., Warren County general practitioner for 52 years, died at his Bowling Green home on February 11 following a brief illness. Doctor Moss, 77, graduated from the Medical Department of the University of Louisville in the class of 1912. A past president of the Warren County Medical Society, he served one term in the Kentucky Senate beginning in 1935. Doctor Moss was an active participant in the medical, civic and church affairs of his community.

WALTER L. SIMS, M.D.
Bowling Green, Ky.
1917 - 1965

Walter L. Sims, M.D., 45, Bowling Green radiologist, died March 10 after an illness of several months. Doctor Sims, a native of Arkansas, graduated in 1943 from the University of Arkansas School of Medicine. After service in World War II he practiced general medicine at Hope, Ark., before completing radiology training.

* * *

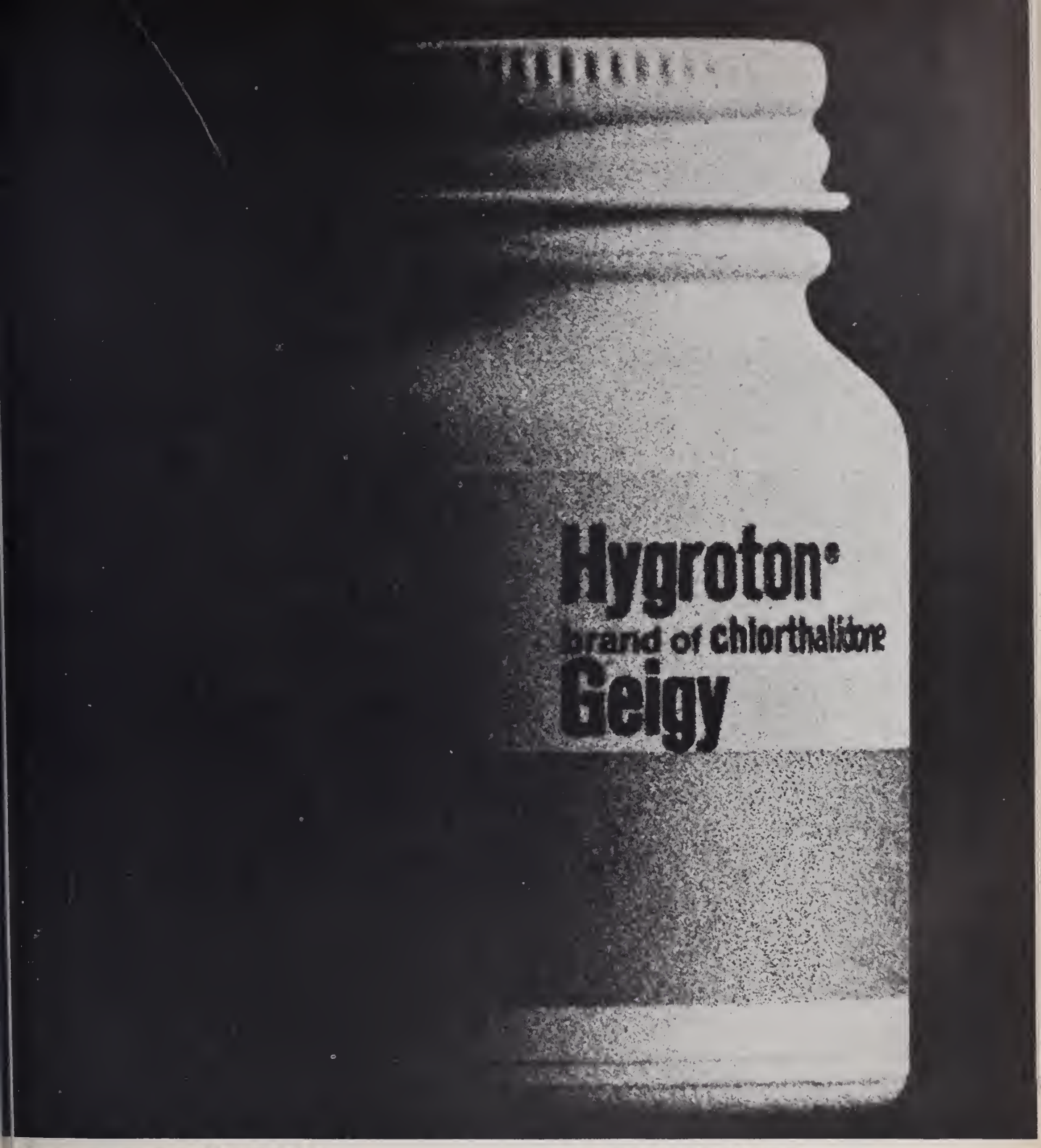
"Plastic Surgery in General Surgical Practice" is the topic of the postgraduate course to be held April 28-29 at the Cleveland Clinic, Cleveland, O. For information and registration blanks, please write to: Education Director, Cleveland Clinic Educational Foundation, 2020 East 93rd St., Cleveland, O., 44106.

Indications: Many types of edema involving retention of salt and water.
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Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
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1965 Annual Meeting — Kentucky Medical Association

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Committee on Scientific Exhibits

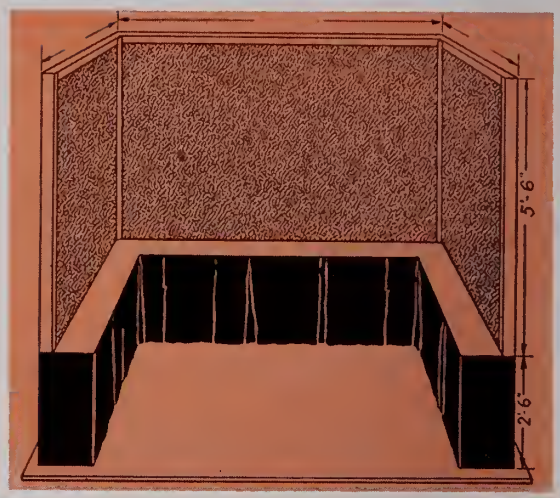
Kentucky Medical Association

3532 Janet Avenue

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1965

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit:
2. Name (s) of Exhibitor (s): (AMA Member?)

 Institution (if desired):

 Mailing Address
3. Do you have a built-in exhibit?
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)

 Charts and Posters.... Photographs.... Drawings X-rays....

 Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:

 Amount of wall space needed?

 Back wall Side walls (All side walls are 4')

 Square feet needed? Shelf desired? (yes or no)
7. Indicate sources of assistance provided in connection with the exhibit.
8. Has this exhibit been exhibited before? If so, when & where?

Date

Signature of Applicant

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

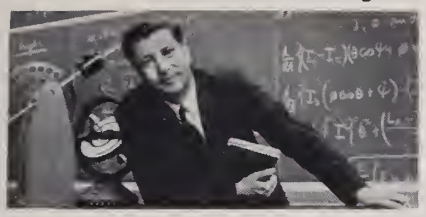
Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

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When anxiety interferes with work, your patient needs a drug that will calm without causing undue drowsiness. With Stelazine (trifluoperazine, SK&F), you can promptly control the anxiety without producing the sedation seen with certain other agents. Anxious patients can remain active during therapy.



Stoll[1] used the drug in 50 patients with anxiety, and noted: "There was no drowsiness in this group of patients and, because of their alertness and less impaired concentration, they were able to continue with and, in some cases, return to their daily work."

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Before prescribing, see SK&F Product Prescribing Information.

Photograph professionally posed.

1. Stoll, L. J.: The Use of Trifluoperazine ['Stelazine'] in General Practice, M. Press 243:578 (June 29) 1960.

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From the files of the COMMITTEE FOR THE STUDY OF MATERNAL MORTALITY



CASE #29-63 — A 37 year old, white, married, Gr. 10, Para 8, Ab 1, was followed at a prenatal clinic beginning at the 14th week of pregnancy. LMP was 3/4/63 with an EDC of 12/11/63. Her course was normal except for an intermittent 1 to 4+ urine sugar. Several postprandial blood sugars were within normal limits. Blood pressure was normal throughout and the patient did not have an excessive weight gain. Blood type was A negative, with Coombs negative. Hemoglobin was 11.1 grams per cent. On 12/10/63 the patient was admitted to the hospital with irregular contractions. Membranes had ruptured spontaneously at 4:30 A.M. on 12/10/63. Physical examination on admission was found to be normal. A vertex presentation with the head floating was found and the cervix not dilated or effaced. She was placed at bed rest. Initial laboratory studies were within normal limits.

The patient spiked a temperature to 102 on the night of the second hospital day but was afebrile the next morning. She was started on penicillin and received one dose before she was found to be allergic to this. She was then given oral tetracycline. The etiology of the fever was not determined.

At 1:30 P.M. 12/11/63 spontaneous labor ensued. Delivery was complicated by a shoulder dystocia with 15 minutes delay. Open drop ether anesthesia was used. At 2:55 P.M. a 9 lb. 14 oz. female was delivered that had marked respiratory depression. Resuscitation for 12 minutes was necessary before spontaneous respirations were established. The baby had convulsions, but improved and was discharged the 25th day of life.

Profuse vaginal bleeding started immediately after delivery and manual removal of the placenta was done. The uterine cavity was explored. No lacerations were noted, but heavy bleeding continued. An IV drip was started with ten units of oxytocin in 1000 cc of 5% dextrose in water. The uterine cavity was packed. Within some ten minutes after delivery it was noted that the patient was cyanotic and irritable as if suffering air hunger. She was immediately intubated and given oxygen. She received 400 cc of whole blood within fifteen minutes after bleeding began and about 400 to 500 cc of the oxytocin solution. She became restless and dislodged the IV. At 3:30 P.M., 35 minutes after delivery no blood pressure was obtainable. The patient was very cyanotic. She did breathe spontaneously but was maintained artificially. A cut-down was performed in the right lower extremity without difficulty and another 400 cc of blood was pumped in, plus two grams of fibrinogen. Cardiac arrest was noted at 4:00 P.M. The patient was given external cardiac massage with some response. Artificial respiration was maintained until 4:35, but the patient was pronounced dead at that time. A blood specimen drawn did clot and did not subsequently lyse.

An autopsy was performed. There was no blood or free fluid in the abdomen. All organs occupied their normal position. The uterus measured 16 x 13 x 8 centimeters. When opened, the cervix was found to be dilated and revealed numerous longitudinal and superficial tears. There was a tear extending from the lower uterine segment to the cervix. This measured eight cm. in length and one cm. in depth. These tears appeared to be the points of bleeding. Examination of the chest revealed no abnormality. The brain was not examined.

Microscopic examination of the lungs revealed many alveoli collapsed. No evidence of a thrombus or amniotic fluid embolism was found. There was an early acute interstitial pneumonuitis.

Cultures of blood, lungs and the uterus did not reveal pathogens. The changes observed microscopically of the heart and lungs appeared most likely to be compatible with a severe early virus infection.

The cause of death was listed as (1) hemorrhage, uterine, postpartum, probably due to a laceration of the lower uterine segment, (2) afibrinogenemia, (3) possible amniotic fluid embolism.

Comment

The Committee classified this death as obstetric direct with preventible factors. During this patient's prenatal course, she had glycosuria which was investigated by two-hour post prandial blood sugars. The committee felt that adequate evaluation of the patient with glycosuria should consist of a glucose tolerance curve or a blood sugar drawn two hours after a loading dose of glucose. In many instances where a patient is requested to come in for a routine two hour post prandial blood sugar, her intake of carbohydrate in the preceding meal will not be adequate to give an accurate index of carbohydrate metabolism.

While it did not contribute to the ultimate demise of the patient, it was the consensus of the committee that any patient who develops fever with ruptured membranes should be thoroughly evaluated and a diagnosis established. When the febrile reaction is due to amnionitis, delivery should be accomplished. It is generally accepted that antibiotic therapy will not control intrauterine infection during pregnancy.

Immediately after delivery when profuse bleeding was encountered, the uterus was quite properly explored, and apparently no laceration palpated. The committee questioned the use of uterine packing to affect hemostasis. This pack will only mask bleeding and it is unphysiologic in that it holds the uterus in a dilated state. Normal hemostasis depends on uterine contraction.

(Continued on Page 300)

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Health Facilities Posts Filled

Four Kentucky physicians were appointed in February by Governor Edward T. Breathitt to serve as members of the Advisory Council for Health Facilities in the Department of Health. The Appointees shall serve as representatives of nongovernmental organizations or groups concerned with planning, operation, construction or utilization of general and special health facilities.

Governor Breathitt named the following physicians to the Council: Robert E. Pennington, M.D., London; Gabe A. Payne, M.D., Hopkinsville; John M. Allen, M.D., Lexington; and Martin Z. Kaplan, M.D., Louisville.

KMA Council and Committee Reports

KMA Board of Trustees

Robert Pennington, M.D., London, Chairman

KMA Headquarters Office **February 4, 1965**

The Board of Trustees of the Kentucky Medical Association held a special meeting at the Headquarters Office in Louisville on February 4.

The matter of KMA participation in the education program for Eldercare was considered, approved and given to the Council on Legislative Activities for implementation.

Routine matters relating to the McDowell Home, committee appointments, and miscellaneous matters were considered.

Primary Enuresis in Children

(Continued from Page 256)

is asked to force fluids during the day and to hold the urine as long as possible. Anticholinergic drugs are useful adjuncts in the effort to distend the bladder and to increase its capacity, which is too small to hold the total output of night urine.

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Maternal Mortality Report

(Continued from Page 298)

Intravenous oxytocin was used in an attempt to control hemorrhage. Oxytocic drugs are ineffectual when the uterine blood flow is inadequate (e.g., in shock). At this point more direct measures to affect hemostasis, including a further search for lacerations should have been attempted. As was noted in the protocol, the patient received 2 grams of fibrinogen intravenously but there was no indication at that time of any systemic hemorrhagic diathesis. The blood specimen drawn from a peripheral vessel did clot well. The committee questioned the wisdom of the use of the fibrinogen. The autopsy did not confirm the diagnoses of afibrinogenemia or amniotic fluid emboli.

The committee felt the major preventible factor was inadequate blood replacement, together with the lack of diagnosis of the source of hemorrhage. Adequate therapy should have included direct surgical intervention with ligation of uterine and/or hypogostric arteries.

COUNTY SOCIETY REPORTS

Adair

George O. Nell, M.D., will serve as president of the Adair County Medical Society for 1965, assisted by W. Todd Jeffries, M.D., secretary. Oris Aaron, M.D., is delegate to KMA, and Doctor Nell will be alternate delegate. All are from Columbia.

Anderson

Boyd Caudill, M.D., Lawrenceburg, is president of the Anderson County Medical Society for 1965 and 1966, and delegate to KMA, it was recently reported. Doctor Caudill will be assisted by the following officers: Lewis Wash, M.D., vice-president; Reuben N. Lawson, M.D., secretary-treasurer; and George F.

(Continued on Page 304)

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AMA Bylaws

Chapter VI. Meetings-Section 2. Registration (A) Members. A Member's Section registration shall correspond with his specialty or General Practice status as designated by him for classification in the American Medical Association Directory. To be accepted for Section registration purposes, a member of a Section who desires to change his registration from one Section to another because of a change in his specialty, shall be required to inform the Headquarters of The American Medical Association by written notice of this intention at least *sixty* days in advance of the Annual Convention.

Chapter VII. Sections-Section 7. Participation in Business Only a*ctive members* registered in accordance with Chapter VI, Section 2 (A) shall have the right to participate in the *business deliberation* of a section.

Please Note

An Active physician member may not *change his Section* registration for voting purposes from one Section to another Section, unless written notice of a change in his specialty has been given the AMA Headquarters at least 60 days (by April 20, 1965) in advance of the opening day of the Annual Convention.

Upon completion of an Active Member's Registration at the AMA Registration Desk, members will not be permitted to switch from one Section registration to another Section registration during the entire period that the AMA Annual Convention is in session.

However, all members are encouraged to attend any and all of the Scientific Section programs. Such attendance has no direct connection with the Section in which an Active Member may wish to be qualified to vote.

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- ☐ Dermatology
- ☐ Diseases of the Chest
- ☐ Experimental Medicine and Therapeutics
- ☐ Gastroenterology
- ☐ General Practice
- ☐ General Surgery
- ☐ Internal Medicine
- ☐ Laryngology, Otology and Rhinology
- ☐ Military Medicine
- ☐ Nervous and Mental Diseases
- ☐ Obstetrics and Gynecology
- ☐ Ophthalmology
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Gilbert, M.D., alternate delegate to KMA. All are from Lawrenceburg.

Barren

R. Russell Starr, M.D., Glasgow, was elected president of the Barren County Medical Society for 1955, it was announced recently. New vice-president of the Barren County group is Paul Pichardo, M.D., Lewis Dickinson, M.D., will serve as secretary, and W. H. Bryant, M.D. and E. L. Marion, M.D., as delegate and alternate, respectively. All the 1965 officers are from Glasgow.

Campbell-Kenton

Don H. Frickman, M.D., Newport, is president of the Campbell-Kenton County Medical Society for 1965. Dexter Meyer, Jr., M.D., Covington, is president-elect.

Richard Allnutt, M.D., Covington, in addition to his duties as vice-president, will serve as a delegate to KMA. Paul Klingenberg, M.D., also of Covington, is secretary-treasurer and a delegate.

Besides Doctors Allnutt and Klingenberg, other delegates are: Ronald Fragge, M.D., Robert Longshore, M.D., and J. R. Stevie, M.D., all of Covington. Alternate delegates are: Donald K. Dudderar, M.D., Newport; Wilbur Houston, M.D., Erlanger; W. Vinson Pierce, M.D., C. C. Hugan, M.D., and C. J. Brueggeman, M.D., all of Covington.

Christian

Guinn S. Cost, M.D., took office January 1 as president of the Christian County Medical Society. Other officers are: Robert M. Coleman, M.D., vice-president; W. F. Payne, M.D., secretary-treasurer; Doctor Cost and Norma T. Shepherd, M.D., delegates to KMA; and Doctor Coleman and Preston T. Higgins, M.D., alternates. All are from Hopkinsville.

Clay

W. E. Becknell, M.D., Manchester, will serve as president of and delegate from the Clay County Medical Society. J. L. Becknell, M.D., Manchester, is the new vice-president and secretary-treasurer. Doctor W. E. Becknell is delegate to KMA, and Ira F. Wheeler, M.D., also of Manchester, will serve as alternate.

Clinton

Ernest A. Barnes, M.D., Albany, has begun the first year of a two-year term as president of the Clinton County Medical Society, and will serve also as delegate to the KMA. Floyd B. Hay, M.D., Albany, the new secretary, will also serve as alternate delegate.

Cumberland

W. F. Owsley, M.D., is the new president of the Cumberland County Medical Society for 1965. Robert B. Chambliss, M.D., will serve as vice-president and delegate to the KMA. Joseph Schickel, M.D., who was elected secretary, will serve as alternate delegate. All are from Burkesville.

Fleming

R. W. Fidler, M.D., will have a dual role this year as president of the Fleming County Medical Society and delegate to the KMA from his county. Assisting him will be W. A. Graham, M.D., vice-president; and Ben F. Allen, M.D., secretary and alternate KMA delegate. All are from Flemingsburg.

Grant

Lenore P. Chipman, M.D., Williamstown, took office January 1 as the new president of the Grant County Medical Society. Vice-president C. C. Waldrop, M.D., is also from Williamstown.

Daryl B. Shipp, M.D., Dry Ridge, will serve as secretary-treasurer of the society, and as delegate to KMA. F. R. Scroggin, M.D., Dry Ridge, is alternate delegate.

Hardin-Larue

Joseph Dew, M.D., Vine Grove, was elected president of the Hardin-Larue Medical Society for 1965. Other officers are: David T. Lewis, M.D., vice-president; Ollie B. Emerine, M.D., secretary-treasurer; Fred C. Rainey, M.D., delegate to KMA; and Leslie Langley, M.D., alternate. All are from Elizabethtown.

Harlan

Alselm C. Hohn, M.D., Harlan, has been named president of the Harlan County Medical Society for 1965. Also named as new officers were: Charles J. Corea, M.D., Lynch, vice-president; James K. Hurlocker, M.D., Harlan, secretary-treasurer; Henry C. Evans, M.D. and Doane Fischer, M.D., both of Harlan, delegates to KMA; and W. H. Stepchuck, M.D., Evarts, and T. G. Craft, Harlan, alternate delegates.

Johnson

A. B. Carter, M.D., was chosen president of the Johnson County Medical Society at the regular monthly meeting of the group February 23 at the Paintsville Country Club.

Other officers are: Jerry D. Fraim, M.D., vice-president; Maurice P. Hall, M.D., secretary-treasurer; Ernest Skaggs, M.D., delegate to KMA, and Paul B. Hall, M.D., alternate delegate. All the officers are from Paintsville.

Laurel

Boyce E. Jones, M.D. is the new president of the Laurel County Medical Society, it was recently reported. Doctor Jones will be assisted in his duties by the following officers, all from London: C. B. Ison, M.D., vice-president; R. E. Pennington, M.D., secretary-treasurer; E. C. Seeley, M.D., delegate to KMA; and S. M. Adams, M.D., alternate delegate.

Letcher

J. B. Tolliver, M.D., Whitesburg, took office January 1 as 1965 president of the Letcher County Medical Society, and will also serve as alternate delegate to KMA. T. M. Perry, M.D., Jenkins, is vice-president and KMA delegate. Carl Pigman, M.D., Whitesburg, will serve for the year as secretary-treasurer.

Lincoln

T. J. Wright, M.D., Stanford, will head the Lincoln County Medical Society for 1965, according to a recent announcement. Other officers, all from Stanford,

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are: H. I. Frisbie, M.D., vice-president and KMA delegate; E. C. Bowling, M.D., secretary-treasurer; and James Blackerby, M.D., alternate delegate.

Marshall

W. E. Gordon, M.D., Benton, took office March 1 as president of the Marshall County Medical Society. Also serving as officers for the coming year will be: H. W. Ford, M.D., Benton, secretary-treasurer; J. R. Miller, M.D., Benton, delegate to KMA; and George C. McClain, M.D., Benton, alternate delegate.

McCracken

The February 24 meeting of the McCracken County Medical Society was held at Boswell's Restaurant, Paducah, with President J. B. Spaulding, M.D., presiding.

"Recent Advances in Radiology" was the topic of Thomas R. Marshall, M.D., associate professor of radiology at the University of Louisville School of Medicine, who presented the scientific program. His talk was illustrated with slides. An informal discussion followed.

After intermission a short business meeting was held. Attendance at the dinner and meeting was considered quite good in spite of the snowy weather.

Montgomery

J. M. Bush, M.D., Mt. Sterling, has been elected president for 1965 of the Montgomery County Medical Society. Doctor Bush's fellow officers, also from Mt. Sterling, are: D. P. Edmundson, M.D., vice-president; R. J. Salisbury, M.D., secretary-treasurer and delegate to KMA; and L. E. Roberts, M.D., alternate delegate.

Nelson

Emmett W. Wood, M.D., Bardstown, will head the Nelson County Medical Society for 1965, it was recently reported. Other officers are: T. G. Forsee, M.D., Bardstown, vice-president and alternate delegate to KMA; and William Yates, M.D., Bloomfield, who will serve as secretary-treasurer and KMA delegate.

Owen

O. A. Cull, M.D., Owenton, will serve as president of the Owen County Medical Society this year, and as delegate to KMA. Maurice Bowling, M.D., Owenton, will be secretary-treasurer and alternate KMA delegate.

Owsley

J. R. Aker, M.D., Booneville, was elected president of the Owsley County Society for 1965. He will be assisted in his duties by Mildred B. Gabbard, M.D., Booneville, secretary-treasurer and KMA delegate; and Caleb H. Y. Chu, M.D., Oneida, alternate delegate.

Pendleton

William M. Townsend, M.D., was elected president of the Pendleton County Medical Society for 1965. Robert L. McKenney, M.D., will serve as secretary-treasurer. Doctor Townsend will be the county's delegate to KMA, and Doctor McKenney, alternate delegate.

Pike

T. I. Doty, M.D., Pikeville, is president of the Pike County Medical Society for the coming year, it was recently announced. Other officers, also from Pikeville, are: Dan Stamper, M.D., vice-president; O. W. Thompson, Jr., M.D., Secretary-treasurer; B. W. Cassady, M.D., KMA delegate; and W. F. Clarke, M.D., alternate delegate.

Pulaski

T. M. Wilson, M.D., Somerset, will head the Pulaski County Medical Society during the coming year. Serving with Doctor Wilson will be Stephen Kelley, M.D., vice-president; and M. C. Spradlin, M.D., secretary-treasurer.

Other officers are: A. L. Cooper, M.D., and Brent Weddle, M.D., delegates to KMA, and B. L. Ramsey, Jr., M.D., and William M. Wyatt, M.D., alternate delegates. All the officers are from Somerset.

Simpson

L. F. Beasley, M.D., is the new president of the Simpson County Medical Society. A. V. Wilwayco, M.D., is secretary-treasurer. Doctor Beasley will also serve as delegate to KMA. Both are from Franklin.

Warren-Butler-Edmonson

Harper Wright, M.D., was chosen president of the Warren-Butler-Edmonson Medical Society for 1965. Serving with him will be the following: Richard M. Beaven, M.D., vice-president; William B. Russell, M.D., secretary; and Thomas Baird, M.D., treasurer.

Other officers are: Martin Wilson, M.D., and Paul Parks, M.D., delegates to KMA; and Waller Griffing, M.D. and William Rowlett, M.D., alternate delegates. The officers are all from Bowling Green.

Pertinent Paragraphs

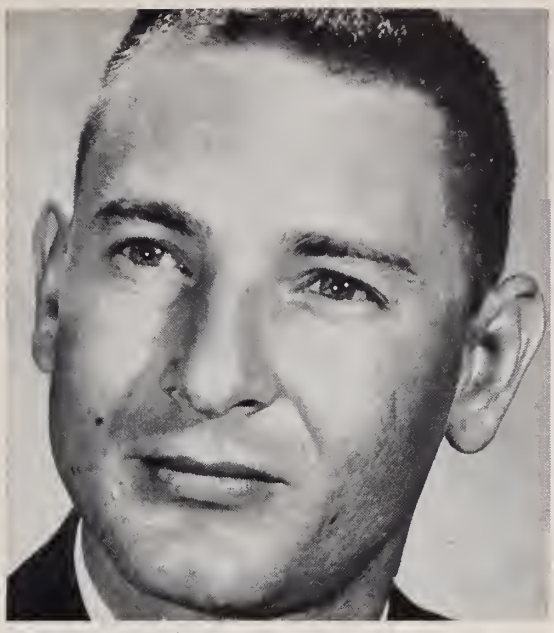
The American College of Physicians has announced its Postgraduate Course number 14, on Rehabilitation, to be held May 10-14 at the Institute of Physical Medicine and Rehabilitation, New York City. Requests for information and registration forms should be directed to Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa., 19104.

The National League for Nursing will hold its convention May 3-7 in San Francisco. Highlights of the program will include seminars on nursing education and careers, and community mental health. For information write to the NLN Housing Bureau, 1375 Market St., San Francisco, Calif., 94103.

The Second National Symposium on Coccidioidomycosis will be held December 8-10, 1965 at the Del E. Webb Towne House, Phoenix, Ariz. For further information contact: Arizona Tuberculosis and Health Assn., Inc., 733 W. McDowell Road, Phoeniz, Ariz., 85007.



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THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION



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1965 KMA Annual Meeting
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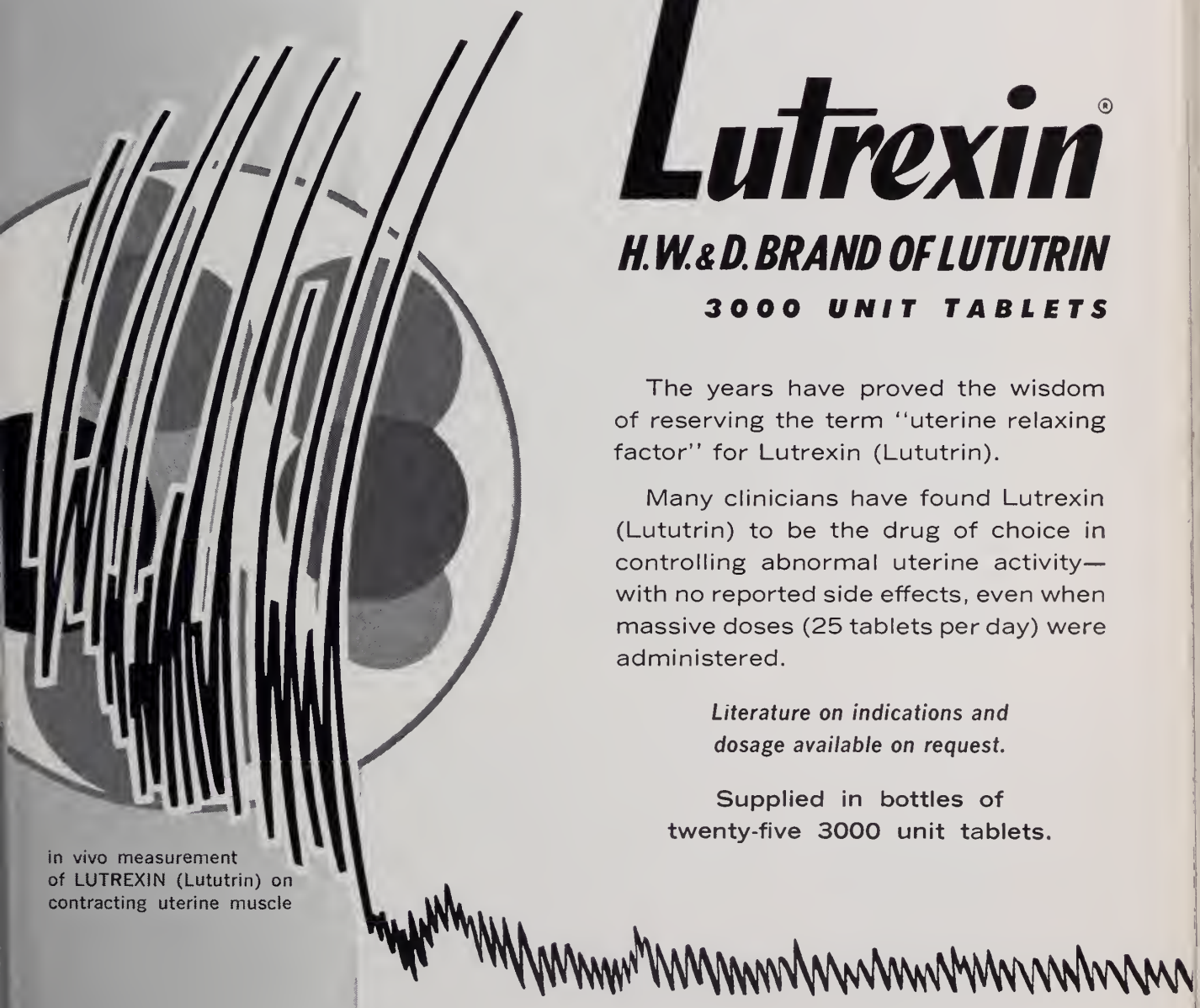
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Age 12-13—not too soon to pay attention to her acne

At the first sign of acne...the first comedone or seborrhea... "this is the time to institute preventive measures—the time to try to prevent progression to pustulation and scarring."[1] Regular, frequent washing with pHisoHex, antibacterial detergent, can enhance any acne management program, help to clear acne skin faster and better.

pHisoHex is more than a superior cleanser. It contains 3 per cent hexachlorophene, an optimal amount. This powerful antibacterial agent is deposited on the skin where, as an invisible, tenacious film, it degerms between washings. Among 67 acne patients who used pHisoHex, "...results were eminently satisfactory."[2] When pHisoHex was used as the wash in another series of 42 acne patients, "no patient failed to improve."[3]

Why not recommend three or four pHisoHex washings daily and exclusively to all your acne patients? pHisoHex provides superior cleansing action and is nonalkaline, hypoallergenic and "kind" to skin. And for "...a very effective topical treatment for acne vulgaris"[4] prescribe keratolytic pHisoAc® Cream along with pHisoHex. pHisoAc Cream contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent and hexachlorophene 0.3 per cent. It dries, peels and masks lesions. Of 100 patients treated with pHisoHex and pHisoAc (and a low-fat diet), 79 showed good-to-excellent improvement.[4]

pHisoHex is available in unbreakable plastic squeeze bottles of 5 oz. and 1 pint, in plastic bottles of 1 gallon. pHisoAc is supplied in tubes of 1½ oz. For complete acne therapy, prescribe or recommend the special *Combination Package* containing both pHisoHex and pHisoAc Cream.

References: 1. Handelman, Cathryn C.: Early management of acne, *Pediat. Clin. North America* 8:265, Feb., 1961. **2.** McLean, I. E. D.; Graham, K. T., and East, M. O.: The treatment of acne; a trial of "pHisoHex," *Practitioner* 189: 82, July, 1962. **3.** Hodges, F. T.: Therapeutic applications of an antiseptic detergent, *GP* 14:86, Nov., 1956. **4.** Wexler, Louis: Treatment of acne vulgaris, *Clin. Med.* 70:404, Feb., 1963.

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MESSAGE FROM THE PRESIDENT



The Fight Isn't Over†

ON April 8, 1965, the House voted 313-155 for passage of the so-called "Medicare" bill, thus ending a phase of a long battle to prevent the socialization of medicine. Kentucky's delegation voted 6-1 in favor of the bill. The final vote, however, was not indicative of the sentiments of Kentucky's Congressional delegation. The vote to recommit and substitute the Byrnes bill was the key vote and was only defeated by 236-191. This measure was supported by five of the seven Kentucky Congressmen. I think we owe these men a vote of thanks for trying to prevent passage of the "Medicare" bill.

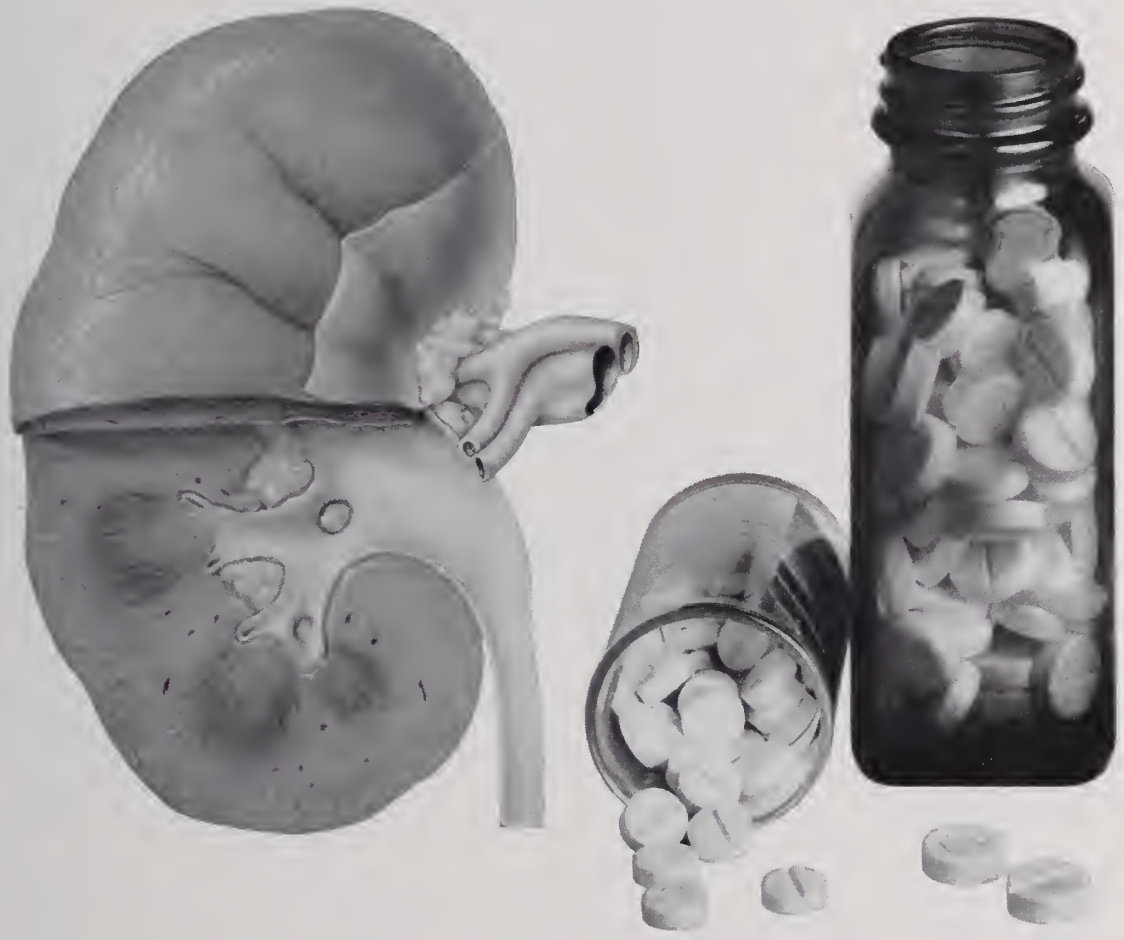
Where do we go from here? The Senate Finance Committee will consider this bill and, we hope, hold full public hearings so the people may know what it contains and have some estimate of its cost. Medicare has good friends on this committee and we plan to carry the fight into the Senate. Even if this bill is passed in the Senate, the fight is not over. We must continue to try to prevent expansion of this bill in future Congresses and the only way we can do this is by electing conservative Congressmen and Senators.

I urge you to actively support your representatives in KMA; your legislative council and KEMPAC. Without your active support we are ineffectual, but with your support we will not be defeated in the final outcome.

HAROLD B. BARTON, M.D.
Vice-President, Eastern District

† *This is the third in a series of four guest articles written at the invitation of the KMA president by the president of the Women's Auxiliary and the three KMA vice-presidents.*

at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

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Anyone can feel tired and "old" too soon. In such functional fatigue, Alertonic helps to lift mood, revive interest, restore purposeful activity promptly. Yet it contains no MAO inhibitors, no hormones. Alertonic is the effective formulation of a cerebral stimulant (pipradrol hydrochloride), alcohol, vitamins, and minerals ... available on prescription *only*. For common functional complaints (mild mood depression, tiredness); geriatric or convalescent patients, Rx one *tablespoonful* Alertonic *t.i.d.*, thirty minutes before meals. Contraindicated in agitated pre-psychotic patients, paranoia, or other patients in whom hyperexcitability, anxiety, chorea, or obsessive-compulsive states are present. Mild central stimulant side effects may occasionally occur.

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Answers to Your Questions on Your Blue Shield

QUESTION: *When does the Blue Shield Medical Endorsement provide payment?*

ANSWER: It provides an allowance on in-hospital medical admissions when there is no surgery, x-ray therapy, or condition relating to pregnancy.

QUESTION: *How is the accident x-ray allowance determined on Schedules "C" and "D"?*

ANSWER: There is an idemnity scheduled allowance provided for the initial x-ray of each part of the anatomy if taken within 30 days of the accident.

QUESTION: *How does Blue Shield determine its allowance on lacerations?*

ANSWER: This is determined by (1) length of laceration, (2) number of lacerations, (3) location, (4) irregular shape, or requiring extensive debridement. Allowances are scaled according to type contract and amount of dues paid.

QUESTION: *Is there any evidence that doctors charge a higher fee if the patient has Schedule D (higher allowances) Blue Shield?*

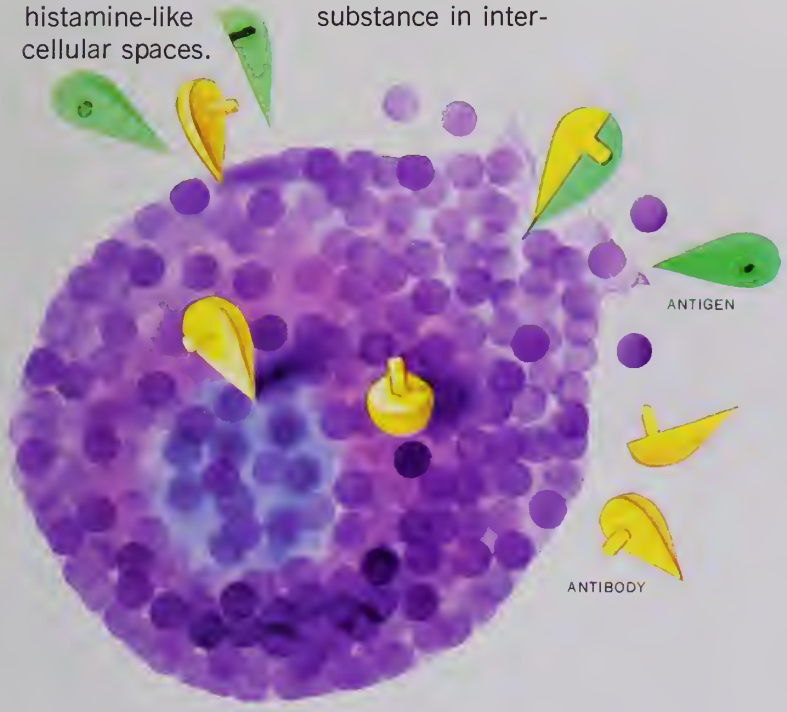
ANSWER: Some Blue Shield subscribers have said that this is so. If it is so, these doctors are defeating the purpose for which members pay the higher dues.

QUESTION: *Why are Blue Shield allowances and doctors' charges so far apart?*

ANSWER: Blue Shield is an indemnity plan, and allowances are based on dues paid. Blue Shield has no control over doctors' charges.

in theory, allergy begins like this:

When antigens invade the body, antibodies, formed chiefly by plasma cells, may become attached to mast cells. If the same antigen reappears and reacts with the antibodies, the mast cell disrupts (as pictured below). Subsequently, the "exploding" mast cell deposits granules of bound histamine or histamine-like substance in intercellular spaces.



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*Schiller, I.W. and Lowell, F.C.: New England J. Med. *261*:478, 1959.

BRIEF SUMMARY: *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until response is determined, patient should be cautioned against engaging in mechanical operations requiring alertness. *Side Effects:* Hypersensitivity reactions, including skin rashes, urticaria, hypotension, and thrombocytopenia have been reported rarely. Occasional transitory drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Other dosage forms available:* conventional tablets (4 mg.); Elixir (2 mg./5 cc.); Injectable (10 mg./cc. ampuls, and 100 mg./cc. in 2 cc. vials).

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basic therapy in low-back pain: bed, board, heat

Whether low-back pain is in the chronic or acute phase, the appropriateness of bed rest for such a patient is beyond controversy. Boards placed under the mattress, for a firmer bed to further immobilize the spine, are another common recommendation. And most investigators consider heat beneficial—moist heat in particular.[1-5]



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(methocarbamol 750 mg.)

(CAPSULE-SHAPED TABLETS)



It has been noted that low-back disorders frequently "... are caused by truly mechanical conditions which yield to conservative treatment."[1] Basic to this conservative treatment are bed rest, a board for the bed, and applied heat. In addition, a good muscle relaxant is often helpful, as "... muscle relaxants are useful in chronic as well as acute low backaches."[4]

Robaxin (methocarbamol) has relieved spasm and pain in cases where the patient "had not responded to conservative measures prior to drug therapy."[6] A 100-patient study showed that Robaxin provided greater relief of muscle spasm for a longer period of time without adverse reactions "than any other commonly used relaxants...."[6]

A well-tolerated[7] skeletal muscle relaxant with "specificity of action,"[7] methocarbamol leaves normal muscle tone unaffected. Moreover, there is little likelihood of sedation[7]—a considerable advantage for the patient who must remain active and alert on his job.

Significantly, clinicians advise using a muscle relaxant "early and in adequate dosage."[8] In this regard, Robaxin (methocarbamol)—*particularly in the 750 mg. dosage (2 tabs. q.i.d.)*—offers optimal therapeutic benefits without a significantly increased incidence of side effects. And just as it works well as part of the basic regimen for low-back pain, so also does Robaxin (methocarbamol) often provide muscle relaxation in such conditions as musculoskeletal injury, chronic neurological disorders, and orthopedic situations.

BRIEF SUMMARY—Robaxin (methocarbamol) Tablets: Contraindicated in hypersensitive patients. Side effects (light-headedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently.

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Robaxisal® (methocarbamol with aspirin) and Robaxisal-PH Tablets (methocarbamol with Phenaphen®).

REFERENCES: 1. Soto-Hall, R.: Med. Sci. *14*:23, 1963. 2. McCarrol, H.R.: Paper read at the Annual Meeting of the American Medical Association, Atlantic City, June 16-20, 1963. See Medical News: J.A.M.A. *185*:39 (July 13), 1963. 3. Gordon, E.J.: Med. World News *5*:54, 1964. 4. Cozen, L.: GP *26*:82, 1962. 5. Larson, C.B.: Postgrad. Med. *26*:142, 1959. 6. Forsyth, H.F.: J.A.M.A. *167*:163, 1958. 7. Weiss, M., and Weiss, S.: J. Amer. Osteopath. Ass. *62*:142, 1962. 8. Rowe, M.L.: J. Occup. Med. *2*:219, 1960.

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IN THE BOOKS

PREVENTIVE MEDICINE—PRINCIPLES OF PREVENTION IN THE OCCURRENCE AND PROGRESSION OF DISEASE: Second Edition: edited by Herman E. Hilleboe, M.D., and Granville W. Larimore, M.D.; Published by W. B. Saunders Company, Philadelphia, 1965; 523 Pages; Price, $12.00.

This is a second edition of a useful and comprehensive volume on how preventive medicine is and should be practiced. It has heavy overtones of why preventive medicine should be practiced by private physicians. Written by some thirty-five specialist practitioners and teachers in the field of preventive medicine, the book is well edited by Doctors Herman E. Hilleboe and Granville W. Larimore. Noting that all the contributors, with one or two exceptions, and that both editors, are presently working or have worked extensively in New York, one is led to wonder if a sub-title "The New York Viewpoint" is not in order. The inclusion of more contributors who had never worked in New York might well have enriched the substance of the text.

The purpose of the book is "to help medical students, physicians and others in the health field understand better how to practice preventive medicine". This it will do, without doubt, if the student, physician or "other (person) in the health field" is motivated to want to better understand how to practice preventive medicine. Perhaps motivation is not to be expected from a textbook.

The book has an interesting, and logical, outline, being made up of three parts. Prevention of Occurrence; Prevention of Progression; and Supporting Services for Preventive Medicine. With lettered Sections, numbered Chapters and an excellent identification of subjects and sub-subjects, the book is easy to read and little difficulty is encountered in knowing exactly what aspect of preventive medicine practice is being discussed at any point in the five-hundred pages.

References appear at the end of each Chapter and are identified carefully and accurately. The index is quite adequate with frequent cross references. Considerable but not excessive use of data to support beliefs or points of view is characterisitc of the text. There seems to be a paucity of graphic illustration. Some of the data given, and this is most surprising in a text written by professional preventive medicine workers, is almost meaningless. For example the reader is shown by a table that in 33.3% of individuals with "positive screening tests for tuberculosis" the family physician confirmed the diagnosis. Some medical students and others seeing this percentage might not notice that the total number of individuals with positive screening tests was three (3)!

Despite the few deviations from what one would expect in a textbook authored and edited by such distinguished individuals, this volume should be placed at least on a par with the two other popular texts on the subject written for medical students and practicing physicians. Being easier to read than one, and more comprehensive than the other, this may well be chosen by many medical schools as the basic text for teaching preventive medicine.

CHARLES F. BLANKENSHIP, M.D.

CLINICAL NEUROLOGY: By Frank A. Elliott, M.D.; Published by W. B. Saunders Company, Philadelphia, 1964; 688 pages; Price $12.50.

This volume is "intended for students and residents" and thus of limited scope. It is quite readable, concise, of nice format, and replete with "pearls" for students. The text is quite up to date, especially in the areas of therapy and modern diagnostic tools. Synonyms are kept at a minimum.

As with any compact volume on clinical neurology, the treatment of some conditions is spottier than others, some are greatly oversimplified and others omitted altogether.

The first third of the book deals with symptoms and signs, emphasizing these somewhat unevenly. The author presupposes a considerable knowledge of neuroanatomy in the reader, more than many students possess. No section on the classical neurological examination is included, but the mental examination is outlined. An arbitrary selection of certain psychiatric topics is presented, often without definition of basic terms.

The book is not a reference work: Many items are out of place, presumably for the sake of brevity. For example, autonomic disturbances of the spinal cord appear under a heading of "clinical aspects of hypothalamic lesions." The bibliography is incomplete and the index only fair. Some basic details are omitted: even the elementary chemical defects of the lipidoses are not defined. Hyperventilation attacks are not mentioned in the differential diagnosis of seizures.

Many "untreatable" conditions such as viral infections receive more attention than, for example, treatable bacterial meningitides. The sections on neoplasms and viscular diseases are good, but the chapter on trauma seems too authoritative. Some serious spelling errors occur in the chapter on peripheral nerves.

The final chapter deals with "diseases of uncertain nature," a highly arbitrary classification. It includes Parkinson's disease, among others, yet many much more "uncertain" illnesses are listed elsewhere.

With the above limitations in mind, this volume provides an adequate survey of neurological conditions.

EPHRIAM ROSEMAN, M.D.

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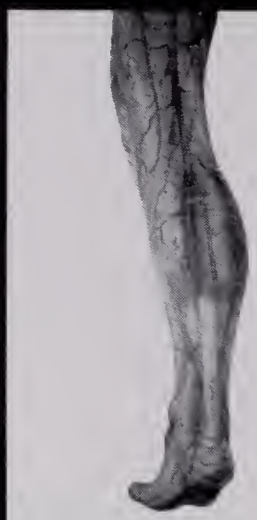
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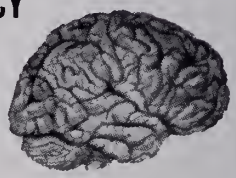
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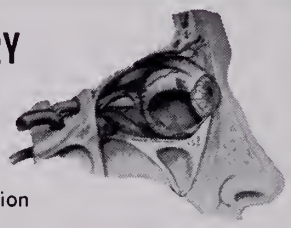
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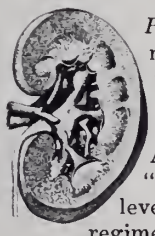
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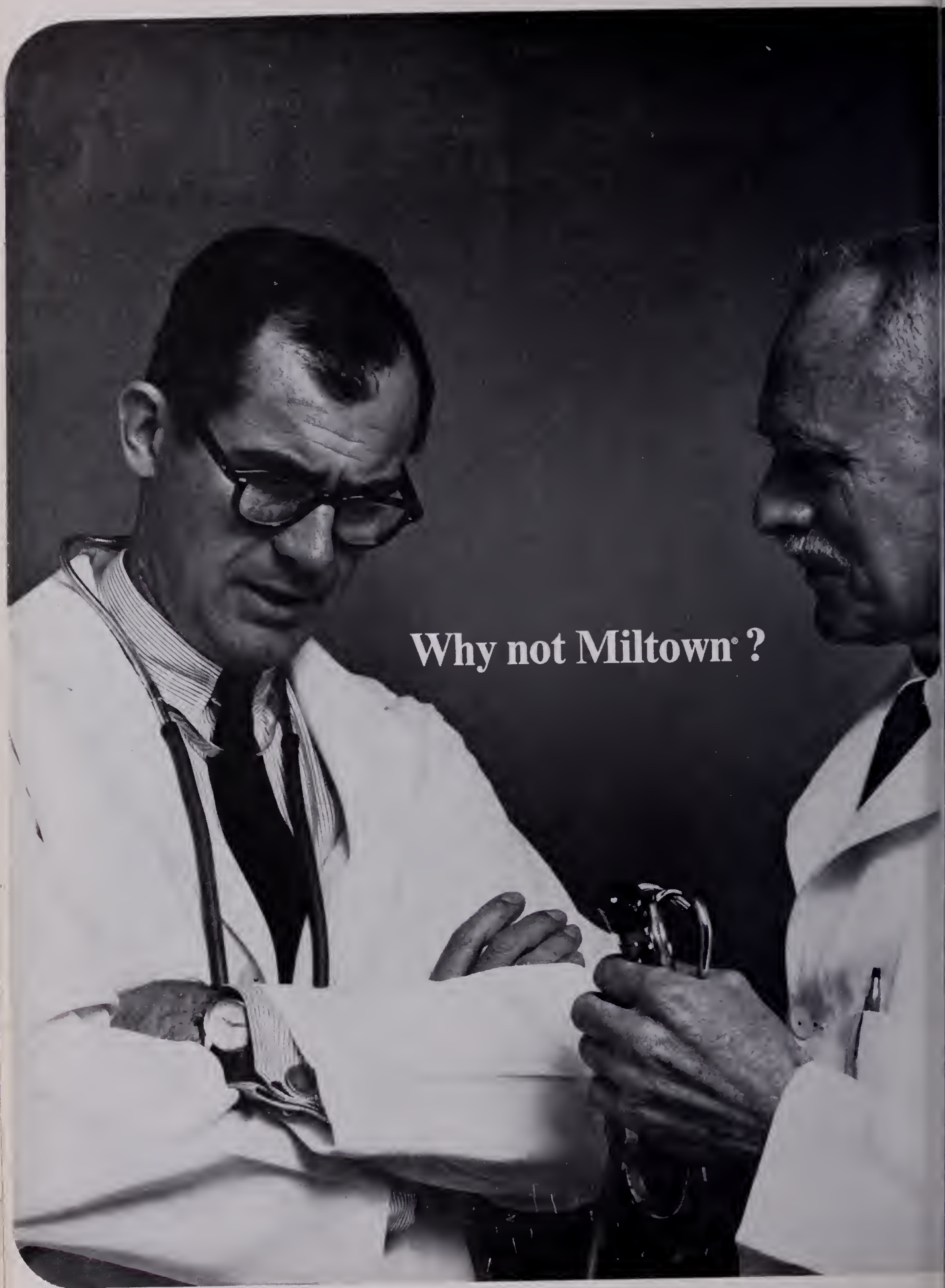
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PUBLIC HEALTH PAGE

Sanitation in Kentucky†

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health, Commonwealth of Kentucky

THE problems attendant to progress in Sanitation in Kentucky are not easily defined nor are they easy to solve.

Many of the older problems are still with us and the technological advancements have given rise to a multitude of new problems.

We still have one-room schools with no modern conveniences such as water supply, sewage disposal, proper lighting, heating and ventilation. Seats of government of several of our counties are still devoid of a public water supply and a sewer system. When you find that the advent of good roads has exposed existing garbage dumps and created new ones, then you know that in spite of progress in some fields we have lack of progress in others. The attitude of the public is changing rapidly with respect to the demand for eliminating those things which are deleterious to the public health and annoying to sight but the fact remains that too few are ready to pay the price of progress.

New chemicals on the market and in every day use in homes and agricultural pursuits now cause us many problems in stream pollution abatement. New processes of industry are now discharging deleterious materials into the air which are extremely hard to identify in combination as discharged into the air. Although medical and other scientific research has shown the dangers of materials taken in excess by eating or breathing, we do not yet have an answer to low level intake over a long period of time. There still remains a gap between what is known and what needs to be known which can only be solved by research. We have learned to control many insects by chemical means, but this is constantly changing as these insects become immune to such chemicals and new and different insecticides must be formulated.

In Kentucky we have long had the pest mosquito and the malaria mosquito but now we are plagued with another one, relatively new to Kentucky which bites in the day time and reproduces in salty and brackish waters. Their very existence threatens our tourist industry in certain localities. Industrially, Kentucky is changing, as evidenced by new factories locating throughout the state. Each must be placed under surveillance with respect to sanitation problems including protection of the health of the workers.

In the milk field, Kentucky, which once received its milk from other states, now ships milk to other states, which means that more work must be done to insure other states that we are shipping a quality product to them. In this respect, it is also noteworthy that Kentucky is the third largest state in the United States in the production of cheddar cheese. The increased activity in milk production by the farms now requires increased inspections.

The tremendous influx of tourists into the state has caused new motels and hotels to be built. Many new tent camping areas have been developed and trailer parks have multiplied with all the attendant sanitation problems. Added to this are the many new and expanded food handling facilities which require surveillance. The mass exodus of people from our cities has caused subdivision development. The creation of lakes by impoundment has caused cabins to be built along their shores requiring sanitary facilities. Now the pleasure craft plying the waters of our lakes and rivers threaten to cause problems of disposal of sewage and garbage which affect public health and esthetic value of our natural resources.

These things mentioned above will only serve to awaken one to how fast things are moving in Kentucky. They should not serve to alarm the public but to make it aware of the responsibilities attendant to progress. What can be done about all these things remains with the community. Each community should dedicate itself to solving the problems of the existing population and see that any expansion is according to set standards of the health departments, planning and zoning agencies, and other public bodies interested in the protection of health and welfare consistent with continued growth. In this respect there are some basic problems that should receive priority, such as:

1. An ample supply of water—safe for use
2. Approved sewage disposal for all people
3. Approved disposal methods for garbage and refuse
4. Approved food establishments with trained personnel for food handling
5. Improved school sanitation in all respects
6. Approved tourist accommodations of all types

The above are only a few of the most important items to be considered, but all are important toward making the community attractive to others as well as the permanent residents. As a citizen each person must dedicate some of his time and energies toward helping the public officials and voluntary organizations to make his community a safer and more attractive place to live.

**This article was prepared by: Ralph C. Pickard, B.S.C.E., M.P.H., Director, Division of Environmental Health, Kentucky State Department of Health, 275 East Main Street, Frankfort, Kentucky.*

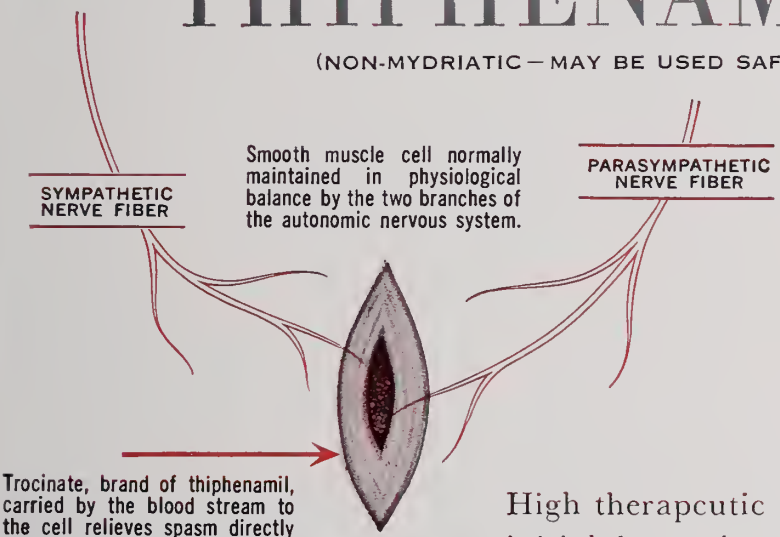
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The JOURNAL of the
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VOLUME 63 May 1965 No. 5

Hospital Staff Issue†

THE several articles in this issue of the Kentucky Medical Journal represent a sampling of the thirteen papers presented at the Seventh Annual Post-Graduate Medical Seminar co-sponsored by the John N. Norton Memorial Infirmary and the Kentucky Chapter of the American Academy of General Practice held at the Norton Memorial Infirmary on December 17, 1964 in Louisville, Kentucky. Regrettably, available space would not permit the inclusion of all the Seminar presentations.



Doctor Lich

The Post-Graduate Medical Seminar was inaugurated seven years ago to provide, in a single day, a rather complete concentrated coverage of some specific or general facet of modern medical practice in an effort to afford the generalist, or the interested specialist, a bird's-eye view of the subject both diagnostically and therapeutically. With the ever growing unfathomable mountainous number of publications crossing the physician's desk it was felt that such a Seminar might afford the registrant both information and provide a sense of direction in coping with his many day to day problems in our ever changing practice of medicine. The Seventh Annual Post-Graduate Medical Seminar was directed toward an evaluation of some of the recent trends in medicine and surgery as opposed to a discussion of the most recent strides which often have a short lived existence.

In this Seminar we were fortunate in having two nationally recognized guest speakers. Samuel P. Harbison, M.D., professor and chairman of surgery and associate dean at the University of Pittsburgh provided a paper in his absence (due to an acute illness) discussing the hazards of iatrogenic diseases and the pitfalls of routinism. On the other hand, William C. Sheldon, M.D., of the Cleveland Clinic, presented some spectacularly informative visual material using cine-fluorography in the diagnosis and therapy of cardiovascular problems.

The Norton Infirmary and the Kentucky Chapter of the American Academy of General Practice are most grateful for this opportunity to present these several papers in a single issue of the Kentucky Medical Journal.

ROBERT LICH, JR., M.D.

† *This special scientific section was assembled from papers presented at the 1964 Norton Infirmary Seminar and prepared for publication by guest editor Robert Lich, Jr., M.D., Louisville, program chairman of the Seminar. Doctor Lich is clinical professor of urology and chief of the section at the University of Louisville School of Medicine.*

Routinism, Iatrogenetics, and Surgical Care

Samuel P. Harbison, M.D.*

Pittsburgh, Pa.

THERE is serious question whether routinism should ever be applied to the medical care of the human being. Each person varies physically, socially, immunologically, environmentally, and psychologically to such an extent that anything other than an individualized approach is unwise, and indeed is unscientific. Although in general we can say that a drug has a certain expected or desired action, in individual cases we are well aware of the tremendous number of exceptions to the rule, exceptions which depend not only upon the drug, the patient's reaction to it, but also upon the circumstances under which the drug was given—the actual doctor-patient relationship. The programs of the American College of Surgeons include "How I Do It" sessions, but no thoughtful surgeon would ever apply the same surgical operation for a certain condition to every patient. This is not only true, for example, of duodenal ulcer where age, severity of disease, nutrition of the patient and other variables must be considered but also to simple mechanical procedures such as the repair of inguinal hernia. How often we are surprised to find a significant variation in the anatomy of certain individuals which must alter our usual or "routine" operation. This is why surgical anatomy must be learned in the operating room rather than the dissecting room. Knowledge of surgical anatomy implies the ability to expose safely the anatomy of that individual, distorted as it may be by disease or congenital anomaly.

If we recognize these variables, and that routinism cannot be applied, we may properly bring into the discussion iatrogenetics, a word which I realize does not exist in the dictionary. We might define it, with help from Dorland, as follows: "a study of disorders induced by the physician by auto-suggestion based on the physician's examination, manner or discussion, and by the actions of the physician during his care of patients." In other words the physician himself has the power to create human ills, and he may do this psychologically or physically, scientifically or empirically. The more complex modern diagnosis and treatment become, the greater the danger of causing complications and physician-induced diseases. However all is not on the bad side. We are deeply indebted to the good effect of iatrogenetics: think for a moment about how we have treated patients for the last two thousand years: we have purged them, we have bled them, we have fed them exotic concoctions of feces, dung, crushed spiders, and other delectable dishes; we have starved them during fevers, cupped them, and treated their battle wounds with boiling oil and red hot pokers. Undoubtedly the physician in these so-called darker periods often practiced euthanasia without him or the patient realizing it. Until fairly recent times we have had no real idea as to what the hell we were doing. How then could it be possible that we as physicians have arrived at the scientific era of the twentieth century as a highly respected group of intelligent and scholarly people? It is obviously because of the tremendous iatrogenic effect of the physician upon the patient, the confidence that he inspired, the comfort he gave, and also because of some great medical discoveries from time to time that enhanced his reputation. So also today we see numerous examples of this powerful iatrogenic or placebo effect in the care of patients. I am quite certain in my own mind that the amount of analgesic needed in the average surgical patient postoperatively is directly related to the confidence which the patient has in the doctor, and the doctor's explanation to the patient what he could intelligently understand of the procedure. When an unexpected complication occurs three days after an operation and another operation becomes necessary, no problem is posed if this doctor-patient relationship has been well-established preoperatively, whereas if it has not, lack of faith, of understanding, and even opposition from patient and relatives alike are the rule. In nonsurgical situations, of course, this relationship is just as important since so often the

*Professor of surgery and associate dean of the University of Pittsburgh School of Medicine, Pittsburgh, Pa.

effect of a drug may be enhanced, or is entirely due to, the trust that the patient has in the doctor who administers it. Could it be that the worry about the disappearance of the general practitioner is based on this factor alone? The sick patient wants the warm understanding and intelligent administrations of a physician and he is not too impressed with the laboratory, the marvelous discoveries and the impersonal approach. However, almost any modern doctor, specialist or generalist, can be a "personal" physician, and still maintain the most competent scientific approach. This is a matter of personality.

If we take the last part of the definition of iatrogenetics—that of the disorders induced by the physician by his actions, we see the reverse side of the coin. Let me quote from Spain's[1] recent book on the subject:

> A few years ago, upon finishing a postmortem examination I encountered a colleague in the hall of the hospital who inquired as to the nature of the case just autopsied. For some strange reason, I engaged in a bit of fantasy and facetiously told him that this was the case of a 37 year old male who five years prior to his demise had been treated for an upper respiratory infection with penicillin. Subsequent to the administration of penicillin he developed a delayed sensitivity reaction. For this cortisone was prescribed, to which he responded with a gastric (stress) ulcer. This ulcer then bled profusely and several emergency transfusions were required. Eventually a subtotal gastrectomy was performed. Several months later he developed homologous serum hepatitis. In the interval a postgastrectomy dumping syndrome appeared and there was evidence of malabsorption. Over the next few years posthepatic cirrhosis developed. At one point, because of the malabsorption, he was fed large quantities of protein. This precipitated the onset of hepatic coma.[1]

This is a totally plausible case history, and I'm sure all of us could give other examples. We all realize that we are dealing with far more dangerous drugs, far more dangerous diagnostic procedures, more extensive operations in which although the risks are higher, dividends are paid where in the past there were no dividends. But this increase in salvage, should we say, does not justify disregard of the obvious unnecessary iatrogenic illnesses. Constant evaluation and consideration of all diagnostic and therapeutic procedures in relation to the end to be accomplished must be the rule.

Surgical Harm

I have included drugs and diagnostic procedures although I know that the surgeon obviously is in the driver's seat in regard to the potential for creating harm. Since I am a surgeon, it is to this area of iatrogenetics that I wish to turn now. Most conveniently the subject can be divided into preoperative preparation, the operation itself and postoperative recovery.

The preoperative period begins in the office when first arrangements are made. The patient may be going to the hospital for the first time, or he may be an old repeater whose hernia you failed to cure several times before, or who has a marginal ulcer. The latter patient will be familiar with the "routines" of the hospital and the impact of his admission and waiting for an operation will not be very great. In contrast the patient who has not been to a hospital, does not realize the indignities which begin at the very moment he is led into his room, he is unfamiliar with the sights and sounds of a hospital, and, about to have his first operation, he is obviously going to be apprehensive. This patient should have had a half an hour or so of explanation in the office to lessen the impact of this strange experience. If this time is not taken it is very likely that the surgeon will find a patient who really is afraid, and his ego may make him ashamed to ask any questions. This opens the way for all kinds of difficulty later on, from poor anesthesia, to ileus, to demands for heavy sedation and all the rest. The two examples given were more or less at two ends of the patient spectrum, but they do point up the absurdity of routine handling or routine orders. Outside of certain basic orders which we consider necessary for minimal evaluation, no others should be routine in any sense. A patient of 22, otherwise in good health, entering the hospital for an elective procedure, certainly does not need the consideration that a patient of 55 needs who is about to undergo operation for a gastric cancer. In the latter case it is quite essential that the work-up include certain basic evaluations of liver, urinary tract, cardiac status, and electrolyte balance since certainly any intelligent surgeon might anticipate problems in the postoperative period. Then

postoperatively if a complication develops he can move from a known baseline of tests. Many years ago I spoke of the absurdity of routine enemas prior to any operation and my belief is a little firmer today. Most colons that I am familiar with empty themselves sometime in the morning. To wash them out at night seems illogical, and to disturb the patient the morning of operation seems unnecessary. I know of no complications resulting from the omission. However, certain people perhaps feel it is their right to have an enema since they are used to it and the physician should be aware of this psychological twist. The thoroughness of the preoperative work-up will of course depend upon the patient's problem and the intelligence of the surgeon. Most important in this work-up is the history and physical examination which may turn up associated conditions that might affect the course of surgery or even the postponement of the operation itself. No diagnostic procedures which are indicated as a result of the history and physical should be omitted, but no block of tests comprising the repertoire of the laboratory should ever be routinely ordered. I have always been amused by the prize offered by a professor of medicine in Pennsylvania each year: it goes to the resident whose patients were well and adequately worked-up but who used the smallest number of lab tests for that year. This whimsy points the finger at the tremendous number of unnecessary tests that we try to justify under the name of thoroughness. The head of our laboratory service recently told me that the number of laboratory examinations for the year has now reached 500,000. He is quite certain from the daily repetition of some of these tests and the nonapplicability of others that they are ordered perhaps more to please the rounding man than for the intelligent care of the patient.

Decry the Routine

I decry certain routine procedures which certain surgeons seem to be somewhat addicted to. The routine insertion of a nasal tube before operations on the stomach, gallbladder, and sometimes other areas is not only uncomfortable for the patient, but also is not necessary in the majority of cases where it is used in this manner. A nasal tube pressing on the alae of the nose can cause damage requiring rather extensive plastic repair later. Nasal tubes left in for long periods of time also can cause ulceration in the pharynx and esophagus, and I am sure that in confused and depressed patients a tube allows stomach secretions to flow up more easily and cause aspiration. Another preoperative routine aided and abetted by the anesthesiologists is to have blood available for almost every laparotomy or thoracotomy. When blood is being taken for other tests it is easy enough to request a typing of the patient, the test tube being left in the laboratory so that should blood unexpectedly become necessary, the crossmatch could be carried out within a reasonably short time. However, routine crossmatching of a pint of blood for every patient undergoing a major operation would seem to be ill-advised quite apart from the fact that if the blood is there, there is a temptation to use it, even though a single transfusion is rarely indicated and if given, might be the means of introducing hepatitis into the recipient.

Patients on steroids, of course, need special attention, the most important of which is the recognition that they are on steroids. Often considerable judgment is necessary in evaluating the necessity for elective operation, since long-term steroid therapy results quite frequently in wounds which fail to heal properly, with subsequent serious complication. Other medications to be reckoned with are the phenothiazines and other tranquilizers. Preparation of the patient with prophylactic antibiotics is still considered routine by some for certain procedures. A recent extensive study of the relationship of prophylactic antibiotics to wound infection points out interestingly enough that the correlation is negative.[2] Preparation of the colon with neomycin, I feel, can be dangerous and is often unnecessary. It is interesting that the commercial manufacturers now put a fungistatic agent in with the neomycin, having recognized its dangers in regard to change of colonic flora. I believe that sulfathalidine and mechanical cleansing can do just as well.

Concomitant Disorders

The finding preoperatively of concomitant disorders both medical and surgical needs careful evaluation to avoid unnecessary iatrogenic complications. Moderate prostatism in association with a projected elective procedure is a different matter from the same problem in a patient with a carcinoma or other urgent disease. The appearance of a hernia in a youth

is not the same as the appearance of a hernia in a 60-year-old man where the etiology might be an obstructive lesion within the alimentary or genitourinary tracts. Poor judgment in situations such as these is an invitation to the creation of a physician-produced disease.

To avoid iatrogenic complications or disasters in the operating room is simply to insure that the surgeon in charge has had good training both generally and technically. This implies competent training long enough to insure adequate experience and to develop surgical judgment, and the "know how" which will insure an adequate team and adequate facilities. We see many unforgivable errors due to inadequate training, such as severance of the eleventh nerve in the process of removing a sebaceous cyst from the shoulder under local anesthesia, the reconstruction of the gastrointestinal tract after gastric resection by gastro-ileostomy and common duct injury not recognized at time of operation. For the most part information on the occurrence of such dismal happenings is obtained from the university centers where such cases are sent—the live ones, I mean. There are many other forgivable but none the less avoidable technical errors that even the best surgeons are heir to at times. Considering the potential for producing iatrogenic complications in the operating room I sometimes wonder how surgeons live so long.

In the postoperative period routinism again becomes significant. In the uncomplicated abdominal case we have been taught to give a certain number of milliliters of fluid as a general rule but this is very often far from the individual patient's ideal needs. For the most part residents seem to err on the side of too much fluid on the basis of calculations learned in books. The texture of the skin, the appearance of the tongue, presence or absence of thirst and the urinary output are still basic indicators of the fluid balance. Let us reserve our laboratory armamentarium for proper indications. Overtreatment of the uncomplicated patient is just as reprehensible, but not as dangerous, as undertreatment of the patient with complications.

The use of analgesics has already been referred to. Pain unrelieved by moderate doses may herald a complication, or may indicate simply a frightened patient. The routine use of the nasal tube postoperatively is to be decried because of the iatrogenic disorders which it may cause. In a recent article supporting this, Herrington and associates were able to omit decompression tubes in 80% of their patients undergoing gastric surgery.[3] With this I heartily agree—and so will four out of five patients who have ulcers which need operation. If this creed is followed, however, there should be no excuse for delay in inserting a tube should there be evidence of gastric atony, distention or early nausea.

A newer problem, involving both routinism and iatrogenetics, has to do with the increased use of indwelling intravenous catheters. Without meticulous attention to every detail these "intracaths" seem to be a very ready source of bloodstream infection. I am reminded of a patient who came in bleeding from a marginal ulcer. He was receiving transfusions from time to time through an indwelling catheter. He developed a high fever which was accompanied by no symptoms except extreme lassitude and headache. A coagulase positive staphylococcus was recovered from his bloodstream and his course returned rapidly to normal with the administration of methicillin. However, in debilitated patients, and in others where there may be a cause for fever this added complication becomes a very serious threat indeed. In most patients intermittent administration of fluid or blood is satisfactory. In those few in whom the risk of an intravenous catheter seems justified, meticulous attention to every detail of asepsis and antisepsis must be maintained. It is a similar situation with urinary catheters, the routine use of which for certain operative procedures seems to have been accepted. However, the indications must be fully justifiable and great care taken not to add the iatrogenic factor of urinary sepsis to an already unprotected patient.

Anticoagulants have certainly been a valuable addition to our surgical armamentarium and under strict supervision in the hospital no one can argue against their use. However, long-term anticoagulation with the patient ambulatory and at home is under considerable scrutiny. The levels may not be constant depending on the individual patient and if kept within a safe range, therapeutic effects may not be achieved. If the patient is actually within the therapeutic range certain complications are recognized and feared. At one of our recent surgical conferences both a neurosurgeon and

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Sigmoidal Diverticulitis

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THERE certainly seems to be an increase in the number of patients who have symptoms originating from inflammation of diverticula of the colon. The increase in frequency is probably due to several factors. One, we have an increase in an older-aged population, and certainly diverticulosis seems to be a degenerative condition of advanced years. Two, physicians certainly are more sensitive, I believe, to our patient's complaints. The patient's complaints are investigated more thoroughly. Subsequently, many more barium enemas are done, and we see many more cases of diverticulosis and diverticulitis. Three, the bland nature of our diet and the reduced physical activity of the older-aged population combine to cause constipation problems and perhaps secondary diverticulosis, and subsequent diverticulitis.

The rule of thirds is probably as good as any to indicate the extent of this condition. A third of everyone over fifty years of age will have diverticula present in the colon. A third of those who have diverticulosis will eventually have infection or inflammation, namely, diverticulitis. Again, a third of those who have diverticulitis probably will require some operative procedure.

For the sake of specificity, the term diverticulum is used to signify a single out-pouch of the colon. These are acquired or false, inasmuch as there is no muscularis between the serosa and the mucosa. The sigmoid is usually initially and frequently solely involved. If more than a single diverticulum is present, then the plural, diverticula, is used. The presence of these defects is referred to as diverticulosis. Inflammation is referred to as diverticulitis. The mere presence of these blowouts is not of concern to us today.

Diverticulitis is a bad disease because it is progressive, and the complications are frequent. Morbidity and mortality are high. Because of the progressive nature of the disease, it is conceivable that a patient can come close to death more than once because of this condition.

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Diagnosis and Treatment

The symptoms of diverticulitis are pain, usually in the left lower quadrant of the abdomen, sometimes peri-umbilical. There is usually a bowel change, either constipation or diarrhea. Occasionally, there is blood in the stool. The patient has anorexia and sometimes nausea and vomiting. The patient may have chills and fever, depending upon the extent of the penetration of the diverticulitis. The patient may have an increase in urinary frequency, or a feeling of pressure on the bladder, secondary to the swelling of the adjacent sigmoid colon.

The physical findings include a sick patient who has tenderness in the left lower quadrant of the abdomen, rebound tenderness, guarding, rigidity occasionally, and, occasionally, a mass. The stool may be positive for blood. The patient may have an elevated white count and fever. It should be easy enough to diagnose this condition accurately, without relying on a barium enema at this stage. A barium enema administered with some degree of force is liable to result in extension of the penetration of the diverticulitis and perhaps perforation into the peritoneal cavity. Sigmoidoscopy is not of great help either at this particular time. Usually the lesion is too high in the colon to be seen through the sigmoidoscope. Additionally, the increase in pressure within the lumen of the bowel as a result of the instrumentation may result in perforation of a diverticulum.

Treatment at this time consists of bed rest and reduced oral intake. If the patient is very sick, it may be necessary to feed him intravenously and to use gastric suction to reduce the amount of intestinal air. Additionally, the patient may need whole blood transfusions. The gut should be sterilized, using neomycin and Sulfathalidine®. Additionally, the patient should have systemic antibiotics, namely, streptomycin and penicillin. Tetracycline is advisable, of course, in those patients who are



FIGURE 1



FIGURE 2

FIGURES 1 and 2. A single diverticulum with local perforation. FIGURE 2. The mucosal surface with perforation indicated by marker. Treatment: Colon resection and anastomoses.

allergic to penicillin. Mild heat can be applied to the abdomen as moist compresses to reduce soreness and spasm. The patient should be given anti-spasmodics. A word of caution is indicated here because so many of these people are well along in years and may develop urinary bladder atonia from the anticholinergics! The patient should be given sedatives and analgesics for his pain. Under this program, the vast majority of these patients will have a quick and effective subsidence of their symptoms. This routine should be sufficient for patients who have acute episodes of diverticulitis or acute, recurrent episodes of diverticulitis.

Eventually, the patient and the attending physician are faced with the problem of how many attacks of inflammation may the patient be allowed to have before he should be operated upon. I believe that surgery should be favorably considered when the frequency of attacks is increasing, when there is a significant degree of obstruction present at all times, certainly when there is persistent bleeding from diverticulitis, when there are frequent urinary symptoms as a result of pressure from the peri-diverticulitis, and when it is difficult to decide by X-ray examination whether the patient has diverticulitis or cancer. I feel that it is particularly important for patients who are under fifty years of age and who have *any* of the above findings to be operated upon.

Surgery

Now, what operation is advisable for these patients? The surgeon probably can do a one-stage resection but I think it is very important not to make any promises to the patient that he won't have a colostomy. The surgeon tries to do a one-stage resection, if the diverticula are confined to a single, resectable area, but he cannot, in clear conscience, do a one-stage resection if there are going to be any diverticula left behind because these then are a source of immediate inflammation, penetration, perforation, and subsequent fistula. It is the development of the postoperative fistula which sounds the death knell of so many of these patients. The preparation for surgery is reduced dietary intake, sterilization of the bowel, and cleansing of the bowel with mild cathartics and enemas.

Urgent surgery is frequently required in patients with diverticulitis. First, let us consider the patient who has extensive diverticulitis with peri-diverticulitis; in other words, an inflammatory phlegmon of the sigmoid with diverticula scattered elsewhere through the colon. The patient requires surgery because of recurrent or persistent obstruction. This is the patient in



FIGURE 3. Multiple perforated diverticular with extravasation.

whom I believe a two-stage resection is indicated. The involved area should be resected and an end-to-end anastomosis and right upper quadrant, transverse colostomy done at the same time. The colostomy, of course, should be complete so that there is no passage of stool distal to the colostomy. This vent will permit healing of the anastomosis, and in about two to three weeks, after a barium enema has been performed to be certain that healing has been accomplished, the colostomy can be closed.

The next step in urgent surgery is that of the three-stage procedure, and this, of course, is applicable when the diverticulitis has perforated or there is extensive abscess formation. Initially, the patient should have a colostomy and drainage of the abscess. The latter procedure should be done extraperitoneally, if possible, by making a small flank incision and putting a large, but flexible, tube in the abscess. Several months later, the area of primary involvement can be resected and anastomosis performed without disturbing the colostomy. Eventually, barium enema examination is used to confirm the security of the anastomosis, then the colostomy can be closed.

A similar operative program is indicated when a fistula develops to the outside, either directly or by way of the bladder, uterus and vagina.

Lastly, the three-stage operative procedure is applicable in those cases in which there is considerable obstruction of the colon. Here, the colostomy again is made in the right upper quadrant, in the transverse colon. The distended and thin sigmoid proximal to the diverticulitis is allowed to regain its tone, a resection is then done, the colon anastomosed, and, lastly, the colostomy is closed. A word of caution is indicated, as far as these patients are concerned. A barium enema should be done fairly soon after the first stage. If the obstruction is due to diverticulitis and its associated edema, there should be a reduction in the obstruction. If the obstruction is due to malignancy, it probably will persist, and, subsequently, the patient should have a resection earlier than those patients who have diverticulitis.



FIGURE 4. The serosal surface with perforations indicated by markers. Treatment: Exteriorization and eventual resection.

Lastly, the problem of imperative surgery for the patient who has ruptured diverticulitis with fecal peritonitis. The patient is presented in a state of collapse. Prompt intravenous fluids, including blood, and intravenous antibiotics are started. The patient has a prompt exteriorization of the sigmoid colon, as a life-saving measure. Later, if the patient survives, he should have a resection and at that time a right upper quadrant colostomy, and then lastly, closure of the colostomy.

Summary

I have tried to point out the indications for elective, one-stage surgery and then the surgi-

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Stabilization of the Spine by Anterior Interbody Fusion

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PAIN and disability in the lumbar area has been one of the paramount problems of orthopaedic surgery throughout most of our era in medicine and has been one of the prime problems of the general medical practice.

There have been numerous theories for the etiology of pain in the low back area as well as many types of treatment for low back pain.

It has been felt in the last few years that one of the most prominent causes for low back pain is instability of the lumbar spine. Instability is particularly prevalent in the lower lumbar area and is by far the most common cause of difficulty in the lower two lumbar segments—that being the fourth and fifth lumbar vertebrae and the fifth lumbar vertebra's attachment to the sacrum. The fourth and fifth disc areas are subject to great mechanical stresses in both active motion of the spine and the static position.

Newer Concepts

This paper will cover some of the newer concepts of the causes of lumbar pain from arthrosis which goes along with aging of the spine and degeneration of the intervertebral discs with or without herniation. Arthrosis of the spine is frequently called degenerative changes by physicians and it is also at times confused with arthritis. Arthrosis is the osseous and nonosseous noninflammatory articular and periarticular changes which occur in the spine both at the anterior portion of the vertebra at the level of the disc and the disc spaces as well as the facets posteriorly.

It is now felt by many authors that the instability of the spine usually starts as an early degenerative or traumatic change in the disc and its surrounding annulus, anterior and posterior longitudinal ligaments.[1]

The intervertebral space and its structures should be thought of as an anterior joint, and the facets and their surrounding soft tissues as a posterior joint in the spinal column. Sprains to these joints should be treated like any other sprained joint; however, due to the overlying large soft tissue structures and smallness of the joints and their deeply placed anatomical position in the human body, the diagnosis is much harder to make than in other joints which are sprained, such as the knee in which the ligament is almost entirely subcutaneous and in which the tenderness, swelling, and thickness of the ligaments are easily palpable in addition to the effusion being readily seen by the examiner. It is felt that these same changes are present in the ligamentous structure around the intervertebral disc space, as well as the facet joints. The diagnosis of injury to soft tissue structures is further complicated by the fact that the structures of the central nervous system are located in proximity to the ligamentous structures and are also encased by the bony structures which allow very little room for swelling and expansion. There is also the element of hydrostatic pressure from compression of the disc space which in turn transmits its forces to the ligamentous structures producing pressure from within and likewise causing stretching of the ligaments, both of which in turn lead to pain.

If this process is allowed to continue with minute injuries to the ligamentous structures followed by healing and scarring, it is logical to think that eventually there will develop much replacement of the normal ligamentous tissue by scar tissue which leads inevitably to derangement in the back and continued degeneration of the intervertebral discs. As this process goes on, the disc spaces settle and undue forces are placed on both the intervertebral joint and the posterior facets. Thus, the changes of arthrosis continue and eventually local traumatic changes in the joints force undue stress upon the ligamentous structures, as well as encroachment upon the adjacent nerve roots. This gives us the symptoms present which are low back

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pain and pain radiating into the gluteal area, thighs, and calves of the leg.

Treatment

Here we wish to emphasize a point which we feel is paramount in the treatment of any back sprain and which should be enforced by the physician to the utmost. It has been too common a practice in the past for the treatment of back pain to consist of medicine for pain and muscle spasm and a plan for getting the patient reactivated as rapidly as possible. This rapid reactivation is in direct contrast to the treatment prescribed for trauma of other joints, in which cases the physician splints the extremity and joint involved until the ligaments have had a chance to heal and only then starts the patient on a program of rehabilitation.

The best treatment for any back sprain in its initial phase is rest, and the only way in which this can be accomplished is by immobilization, which is attained only by absolute bedrest. This should be followed by a period of bracing for protection of these ligamentous structures and then the patient started on a program of exercises for rehabilitation of his back. The whole program of treatment becomes a problem of utmost importance to the physician as he is the only one who understands the basic underlying pathology. He must protect the patient until he is healed in order to return him to his useful position in society, and his livelihood, which in many cases includes the use of his back.

When instability of the back has developed due to chronic repeated sprains or sudden traumatic sprains, which do not heal properly, the patient may have developed an asymptomatic degeneration in his disc and changes in his surrounding ligamentous structures of which he is unaware until some incident upsets nature's attempts to heal. He may have also developed such extensive arthrosis that the continued activity keeps his derangement in an active state. At this time, if he has not responded to the usual conservative methods, surgical intervention for stabilization of the spine is indicated.

The surgical treatment for stabilization of the lumbar spine has been posterior lumbar fusion, as described by Hibbs in 1911, and popularly used until recent years. This procedure has had many variations of technique in order to attempt to improve the results but it has a significant failure rate due to the instability at the intervertebral disc space. This instability is still present to a certain degree even with a solid fusion of the posterior elements, and there have been frank herniations of the discs.

Instability developing following excision of the disc and later requiring a fusion for stability has led us in recent years to excise the disc anteriorly and do an interbody fusion at the same time. Such a procedure, we feel, gets rid of both the pathologic process and stabilizes the spine.

Anterior Interbody Fusion

The technique for stabilizing the spine by an anterior excision of the disc and interbody graft is basically removal of a portion of the iliac crest for graft material and an anterior approach to the spine by the retroperitoneal route with exposure of the disc and then excision of the disc and replacement by bone graft.[2]

This procedure is done through an incision over the iliac crest midway between the tuberosity of the iliac crest and the anterior-superior iliac spine. The section is carried down through the skin and subcutaneous tissues and the fascia of the tensor fascia lata is incised at its attachment to the iliac crest. The tensor fascia lata muscle is then stripped subperiosteally until the iliac crest is exposed. Then a circle saw drill is used to remove a three-quarter inch diameter plug of inner and outer cortex of the iliac crest. Usually two of these plugs are required to do the intervertebral graft at one level. Any bleeding from the bone is controlled by bone wax and then the fascia is reattached to the iliac crest and the subcutaneous tissues and the skin closed.

A left paramedian incision is then made from the symphysis to the umbilicus and the section is carried down through the skin and subcutaneous tissues. The anterior fascia of the rectus is incised and the rectus is dissected free and retracted laterally. The epigastric vessels are visualized and protected to avoid damage. The dissection is next carried out around the lateral wall with the peritoneum being dissected free from the abdominal wall until the iliacus and psoas muscle are exposed. The peritoneum is dissected free from the lateral wall and the iliopsoas muscle by blunt dissection. The left common iliac artery and vein are visualized along with the ureter and

the ureter is either dissected free and left in its bed or is dissected to the right along with the peritoneum and its contents.

The left side is always approached rather than the right as the vena cava is usually to the right side and by the left approach can be retracted to the right much easier.

The fifth lumbar disc space is now easily located by palpation with the finger as the prominence of the lumbosacral joint is easy to palpate. Following this, the disc space is exposed. Usually the middle sacral artery and vein pass over this space and can either be ligated with 3.0 silk suture or clamped with a silver clip. Sometimes these arteries and veins are small enough to be controlled well with a cautery.

Blunt dissection is then used to retract the right common iliac vein to the right and the left common iliac vein to the left. This exposure is maintained by using a special spike retractor which can be driven into the vertebrae to give a good exposure to the disc space.

The disc is excised by dissecting out the anterior longitudinal ligament and annulus overlying the disc. The ligament may be preserved and resutured if desired.

Following the removal of the contents of the disc space, the cortical plates of the vertebra above and below are scraped with a curette down to the bone, and all cartilaginous portions are removed. A hole is then drilled in the intervertebral space and the grafts are inserted into this space.

The fourth disc space may be exposed by a blunt dissection starting just to the left side of the aorta and vena cava at the interval between these vessels and the psoas muscle. The vessels are retracted to the right and the disc space is exposed by continued blunt dissection and retracting of the vessels to the right side. If they are present, the communicating veins which cross in this area may be ligated with silk sutures or silver slips. These same spike retractors are used to keep this space exposed and the identical technique is used to excise this disc and replace the intervertebral space with bone grafts. The bony bleeding which is present at this area can be controlled by packing the area for a short period of time with a sponge or by using a small piece of Gelfoam® or Surgicel® over this area.

The peritoneum and its contents are allowed to fall back into position. The anterior erector sheath is closed and next the subcutaneous tissue and skin incision is closed.

Postoperatively the patient is kept on a liquid diet until his temporary ileus has subsided and then is placed on a progressive diet. The day following surgery he is ambulated and this helps control his ileus. If he develops difficulty in voiding, a Foley catheter is inserted, otherwise he is allowed up and about as he desires, using an abdominal binder the first two or three days of his postoperative course, followed by use of a William's brace when he is ambulating. He is also started ambulating with a walker, as the soreness in the iliac crest usually prevents him from full weight bearing on the leg.

Patients are allowed to continue ambulating as they desire in their braces and are usually ready for discharge in approximately two weeks. They make office visits at monthly intervals and x-rays are taken to determine the progress of their fusion.

Summary

Instability of the lumbar spine is secondary to disc injury and/or degeneration. An anterior interbody fusion, wherein the disc is excised and replaced by a bone graft, eliminates progressive disc degeneration and affords positive spine stabilization thus preventing future pain caused by instability in the low back area.

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Pregnancies, Placentas, and Potent Potions

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WE HAVE long been aware that some drugs administered to a pregnant woman could appear in the fetal circulation and could cause fetal damage. The full impact of such damage was realized in 1961 when thalidomide made the headlines.

Many drugs which are harmless to the mother have unforeseen and sometimes undesirable effects on the fetus. Drug metabolism is a greater problem in the newborn because of immature and inefficient enzyme systems.

It is believed that any substance found in the fetal or maternal blood should be able to penetrate the "placental barrier" to some extent unless it is either destroyed or altered during passage. A low degree of permeability may slow entry to a rate which renders a drug physiologically inactive and pharmacologically undetectable. Page suggests that the important question is not whether a given substance does or does not pass but rather the rate and mechanism of transfer involved.

An effort will be made to discuss some of the more important drugs that must be used only at small or great risk to the fetus. Any list compiled today will be incomplete tomorrow.

Cancer Chemotherapeutic Agents

Folic acid antagonists (Aminopterin, Methotrexate) are most potent potions. When given at usual dosages in the first trimester, these drugs almost always cause either abortion or severe fetal anomalies. 6-mercaptopurine (Chlorambucil), triethylene melamine (TEM), busulfan (Myleran), and nitrogen mustard have teratogenic effects in experimental animals. At the present time there have been no reports of adverse effects on the human fetus when these drugs are given after the first trimester. Follow-up studies are incomplete for even brief periods and it may be ten years before the true facts are known; defects in some tissues, i.e., ovaries and testes, may be apparent much later.

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Antibiotics

Silverman of Babies Hospital (New York), being aware of the impaired metabolism of sulfa drugs in newborns, sought to protect these infants from infection. Gantrisin was given to mothers prior to delivery, thus elevating the infant's blood level via the placenta. Indeed, such protection was afforded; however, the death rate among such prematures increased in spite of negative blood cultures.

Why? Kernicterus was present in 50% of the infants at autopsy. Bilirubin determinations were available in about one half of these infants and although elevated, almost never exceeded 15mg. It appears that sulfas interfere with protein binding of bilirubin and thus permits passage across the blood brain barrier.

Kynex, Madribon, and Midicel are found in infants' sera for several days after birth. The use of these long-acting sulfas may be more dangerous to the newborn than the rapidly excreted type because of their persistence and apparent tendency to bind more securely to the plasma proteins.

It is of interest that aspirin is highly effective in causing disassociation of bilirubin and plasma proteins.

Chloromycetin and Terramycin also interfere with this protein binding but only if given in unphysiological amounts. Chloromycetin may cause hyperbilirubinemia by competing for conjugation. It may cause circulatory collapse (the grey syndrome) in newborns.

Streptomycin and dihydrostreptomycin may cause deafness in the infant if used during pregnancy. No such complication has been reported after the use of Kanamycin.

Isoniazid administration may cause fetal blood levels which actually exceed maternal values. In view of the known toxic side effects of this drug on the central nervous system and other vital organs, it seems advisable to bear in mind the possible hazard to the fetus of prolonged exposure.

Tetracycline used during pregnancy may cause adverse effects on the deciduous teeth. When the drug is given after calcification has

begun (the fourth month) anomalies (yellow florescence, gross color changes, caries, and enamel hypoplasia) may result. The possibility of skeletal deformities of fetus has recently been raised and partially documented.

Drugs Causing Masculinization of the Female Fetus

Wilkins published a collection of 70 cases of masculinization of female infants due to progestational agents. Thirty-four were caused by 17-a-ethinyl testosterone (Progesterol, Pronone, Lutocylol) and 36 were due to Norlutin. A much smaller dosage of Norlutin was necessary to cause these changes.

Jacobson analyzed pregnancies in which Norlutin had been given during the first trimester. Seventeen of 53 females showed masculinization. The incidence was so high that there is little doubt this product is contraindicated in the treatment of threatened abortion. There are other drugs equally effective in the prevention of abortion and one is not justified in taking a calculated risk by using either Norlutin or Norlutate.

Norlutate has largely replaced Norlutin but the primary step in the metabolism of this drug is conversion to Norlutin. At least three cases of masculinization associated with the use of Norlutate have been reported.

Burstein and Wasserman have reported transient hypertrophy of the clitoris when oral Provera (25 mg. per day for seven days) was given for threatened abortion. At six months the genitalia were said to be normal. Stubbs has knowledge of two additional cases of temporary masculinization of the famale fetus.

Only one case implicating Enovid has been reported.

There have been no cases implicating Duphaston.

Grumbach has reported 14 cases of masculinization due to testosterone and similar products. Only small doses are required. The mother will probably not show any adverse reactions.

Bongiovanni reported four cases following the use of large doses of stilbestrol. I am not aware that Karnaky has reported this complication. It is possible the change is due to stimulation of the fetal adrenal gland or that estrogen metabolism may be abnormal in these mothers.

Adrenal Corticoids

Despite the fact that Bongiovanni reported two cases of cleft palate possibly related to the use of cortisone (and the proven teratogenic effects in lower animals), man seems to be an exception to adverse effects when corticoids are given during gestation. However, it would seem wise to avoid the use of these drugs during the first trimester.

Antithyroid Drugs

The fetal thyroid begins to function prior to the fourteenth week of pregnancy (perhaps as early as the sixth week) and thereafter becomes subject to the effects of such substances as radioactive iodine, potassium iodide, propylthiouracil, and methimazole. Some goitres are transient while others persist for months. The amount and duration of the use of these drugs during pregnancy seems to have a direct influence. Thyroid may be given concurrently to prevent goitre if antithyroid drugs must be administered but a better solution to the problem is thyroidectomy.

Vitamin K Analogues

Certain drugs are associated with increased jaundice and hyperbilirubinemia in newborn infants, thus exposing them to an increased risk of kernicterus. Synthetic vitamin K analogues (Synkovite, Kappadione, Hykinone) may cause this complication when given in large doses. Premature infants are especially vulnerable.

Natural vitamin K and K_1 oxide have not been incriminated. Complications following antepartum or intrapartum injections of 1 or 2 milligrams of vitamin K analogues have not been reported.

The mechanism seems to be excessive hemolysis. There is, in addition, evidence that vitamin K analogues are hepatotoxic to the newborn. The process is further complicated by the fact that vitamin K analogues are partially excreted as glucuronides, thus competing with bilirubin for glucuronyl transferase hepatic enzyme system.

Hemolytic anemia may also occur following exposure to naphthalene, primaquine, nitrofuradantoin (Furadantin), phenylhydrozine, sulfonamides, and other anilene derivatives. The red blood cells of individuals susceptible to hemolytic anemia seem to be deficient in glucose-6-phosphate dehydrogenase.

Ingestion of moth balls by a mother during pregnancy has been reported by Zinkham and Childs. The infant suffered hemolytic anemia and subsequent hyperbilirubinemia.

Substances Metabolized by the Liver

Sulfonamides, cortisone, estrogen, progesterone, aspirin, menthol, and chloramphenicol are detoxified by the liver. Liver functions are poor in the newborn; therefore, these substances are detoxified slowly and ineffectively. In most cases this seems to be of little clinical importance; however, in the case of sulfas and chloramphenicol such is not true. These latter two drugs have already been considered under antibiotics.

Drugs Associated with Hepatic Toxicity

Toxicity has been observed following sulfonamides, chlorotetracycline, anticonvulsant drugs, prochlorperazine (Compazine), chloropromazine (Thorazine), phenobarbital, and other phenothiazines. It would appear that reaction is on the basis of individual idiosyncrasy.

Drugs Causing Thrombocytopenia

Crosby and Kaufman recently tabulated a long list of drugs which could cause thrombocytopenia. Some of the more important drugs are quinidine, chlorothiazides (Diuril), acetozolamide (Diomox), sulfasaxazole (Gantrisin), phenylbutazone (Butazolidin), and meprobamate (Miltown, Equanil). When drug-induced thrombocytopenia of the mother occurs, a transitory thrombocytopenia of the newborn will probably result.

Anticoagulants

Heparin does not cross the "placental barrier" in significant amounts and therefore is safer than other anticoagulants. Opinions vary concerning fetal hazards when Dicumarol and similar drugs are given to the pregnant patient; however, there is little doubt these drugs are capable of causing intrauterine and neonatal deaths. The fetus may be unusually vulnerable since death may occur despite normal prothrombin time.

Epsilon aminocaproic acid (EACA, Amicar) crosses the "placental barrier" and should be used in the immediate antepartum period only after a diagnosis of fibrinolysis has been established. Fibrinolytic activity normally present in the newborn may be inhibited. Recent reports link hyaline membrane disease with a failure in fetal fibrinolysis.

Hypotensive Agents

Reserpine may cause nasal discharge, costal retraction, lethargy, and anorexia during the first two days of extrauterine life. Nasal congestion of such magnitude as to cause respiratory distress has been reported.

Hexamethonium bromide has caused paralytic ileus in a premature infant.

Narcotics and Narcotic Antagonists

Newborns of narcotic addicts present grave problems. A daily maternal dosage of 120-140 milligrams of morphine or 6-12 milligrams of heroin is necessary to produce withdrawal symptoms. It is observed that turbulent fetal movements occur in utero during periods of maternal drug withdrawal and then become normal again when the mother receives injection of the addicting drug.

The infants are small and within 24 hours extreme neural excitation is noted. The infant becomes increasingly restless, irritable, and tremulous. The cry is shrill and unremitting. Motor activity is constant and associated with frantic sucking of fingers and scratching of the face. Fever, vomiting, diarrhea, and dehydration are common. Feedings are taken poorly and regurgitated. Periods of apnea and convulsions occur. If untreated, the mortality rate may be 70 per cent. Treatment includes paregoric, barbiturates, and other sedatives and may be needed as long as four to six weeks.

Nalorphine (N a l l i n e) and levallorphan (Lorfan) are indicated only as antagonists when neonatal respiratory depression is due to morphine, morphine derivatives, or synthetic agents. Should the depression be due to other analgesic or anesthetic agents or to mechanically induced hypoxia, the use of morphine antagonists will not only fail to help but will intensify the respiratory depression.

Oral Hypoglycemic Agents

Jackson and Campbell reported 19 cases of diabetes treated with chloropropamide during pregnancy. The fetal mortality rate was 65 per cent. Only five infants survived when dosages of 500 milligrams were needed. Deaths were respiratory in nature.

It appears that chloropropamide is contraindicated in pregnancy — even the manufacturers agree. Oral hypoglycemic agents do cross the "placental barrier." The sites of action are controversial and need to be more clearly elucidated. The possible teratogenic effects should be carefully studied before these drugs are used during pregnancy.

Thalidomide

Milligram-for-milligram thalidomide is the most potent of the potions. A single 100-milligram tablet may cause severe deformity if given on days 28 to 42 of gestation.

In 1960 Kosenow and Pfeiffer exhibited two infants demonstrating phocomelia at the German Pediatric Meeting in Kassel but drew little attention. In 1961 many clinics noted large numbers of phocomelia which had heretofore been very rare.

The essential feature of the abnormality concerns long bones of the extremities. The upper extremities are most frequently affected and either or both arms may be affected. Lower extremities may also be involved. Abnormalities were found also in the cardiovascular system, gastrointestinal system, central nervous system, and ears. Midline fascial hemangioma on the forehead which extended over the nose to form a "mustache" on the upper lip is almost pathognomonic of the syndrome.

Thalidomide was found to be an excellent sedative in humans, but has no such action on animals. It could not be used for suicidal purposes. It became the favorite sedative in West Germany and was widely used in hospitals. It was added to other drugs for treatment of grippe, neuralgia, asthma, and cough. It was used as a tranquilizer. The antiemetic properties were utilized to treat nausea of pregnancy. It was exported to the British Commonwealth and Portugal and was manufactured (but never sold) in the United States. It was manufactured by the tons in West Germany and sold over the counter without prescription.

It is of interest that following this catastrophe further animal experiments were done. Fetal anomalies occurred when pregnant rabbits were fed thalidomide.

Miscellaneous

Certain drugs used in the treatment of migraine headache may cause abortion and are contraindicated during pregnancy. Cafergot, Ergomar, Migral, Gynergen, and Wigraine contain ergotamine tartrate. D.H.E. 45 contains dihydroergotamine methanesulfonate.

Thus far teratogenic effects of metronidazole (Flagyl) have not been demonstrated; however, it is felt that this product is contraindicated in pregnancy at least during the first trimester.

There was some concern about meclizine (Bonadoxin, Bonine) after the thalidomide incident, but it seems that meclizine is very safe and can be used (as it has been millions of times) in the treatment of nausea and vomiting of early pregnancy.

Conclusion

There is no doubt that drugs do cross the "placental barrier" and may cause severe damage to the fetus. Events will arise when it is necessary to treat a pregnant patient "with vigor" to save her life and, therefore, one must take a calculated risk. It seems to be one thing to have Aplastic anemia following Chloromycetin therapy for typhoid fever, but another to have the malady following the use of the medication to "cure a cold."

It would seem reasonable to avoid the use of any new drug until the teratogenic effect has been studied. This may not be enough however; remember thalidomide will not cause sleep in animals—cortisone has definite teratogenic effects in animals but apparently not in man.

Professor Lenz of Hamburg has said, "Every tablet given to a woman in early pregnancy is an experiment in human teratology."

Bibliography

Note: Due to a lack of space, it was not possible to carry the author's carefully documented references. Therefore, the bibliography will be available upon request from The Journal Office. Editor.

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Head Trauma: "Blow-Out" Fracture of the Orbit

Roderick Macdonald, Jr., M.D.†

As a result of head trauma, fractures may occur which involve the bony orbit of the skull, together with alterations of the orbit and adnexal structures. These changes are of importance to the ophthalmologist both for the immediate care of the patient and also because of the late changes which may occur. In many cases, the initial care of the patient is in the hands of the neurosurgeon or general surgeon so that treatment becomes a joint endeavor and one must, in addition to immediate diagnosis and care, be completely aware of all the possible complications as diplopia, ptosis, enophthalmos, lacrimal dysfunction, and bony malunion, which may occur in the course of the illness.

Orbital fractures may be due to direct blunt violence falling on the orbit, as for example from a baseball or bottle striking the orbital rim or indirect as in the case of radiating fracture lines extending so as to involve the orbit.

The following two cases illustrate an entity to which increasing attention has been paid in recent years; namely, "blow-out" fractures of the orbit.

Case #1: A 19-year-old, white male was admitted to the Louisville General Hospital on April 9, 1964, with a chief complaint of being struck in the face with a shoe shortly prior to admission, the blow landing just below the right eye. A sudden onset of diplopia followed the traumatic episode. The past medical history was not significant.

Physical examination showed a healthy young white male in no acute distress whose visual acuity was not subjectively diminished in either eye. Examination of the left eye and orbit was not remarkable. There was marked edema and ecchymosis of the right upper and lower lids. The right globe was intact but movement of the globe was painful, especially in attempted downgaze. There was marked limitation of both upward and downward gaze of the right eye. Diplopia was present in all fields of gaze. There was marked anesthesia over the distribution of the infra-orbital nerve below the right eye. The orbital rim was intact to palpation.

An initial X-ray study of the facial bones showed a fracture and depression of the superior surface of the right maxillary antrum.

This was followed with planograms in the Waters position which demonstrated well a "blow-out" type fracture involving the floor of the right orbit with a well defined mass projecting into the right maxillary antrum.

Case #2: A 30-year-old, white female was seen in the emergency room of the Louisville General Hospital on May 5, 1964, with a chief complaint of being struck in the left eye by a fist three days previously. This injury was followed by swelling around the left eye, intermittent diplopia, and pain in attempted movement of the eye. The past history was not significant.

Physicial examination revealed a healthy, young white female in no acute distress. Visual acuity was normal in both eyes. Examination of the right eye was not remarkable. Examination of the left eye revealed moderate ecchymosis and edema of the upper and lower lids. The orbital rim was intact to palpation, and there was no infra-orbital anesthesia. A subconjunctival haemorrhage was present but the remainder of the globe showed no abnormality. There was marked limitation of motion in both up and down gaze accompanied by pain in attempting these positions of gaze. Horizontal movements were not affected. The left eye was slightly higher than the right.

Initial X-ray studies of the left orbital demonstrated a mass protruding into the left antrum from above but not definite evidence of fracture. Planograms in the Waters position confirmed the presence of a mass extending into the antrum and, in addition, showed evidence of a linear fracture of the floor of the orbit without displacement of fragments.

Discussion

"Blow-out" fractures differ from other types in that the orbital rim remains intact but the floor is fractured. Pfeiffer, cited by Converse and Smith[1], found in a series of 120 fractures of the orbit that the floor was implicated in 24 cases without involvement of other facial bones. Neely[2] described diplopia in the upper fields of gaze. Schjelderup[3] pointed out the relations of adhesions or pinching of the orbital contents in the fracture lines of the orbital bones.

†*Associate professor of ophthalmology and executive director of the department of ophthalmology at the University of Louisville School of Medicine.*



FIGURE 1. "Blow-Out" fracture of left orbit. Note antral clouding.

The floor of the orbit thins posteriorly so that application of a relatively uniform force to the orbit with resultant elevation of intra-orbital pressure results in a collapse of the orbital floor into the maxillary sinus. The inferior rectus and inferior oblique muscles are herniated through the dehiscence in the orbital floor setting the stage for diplopia. The escape of the orbital fat pad is the major cause of enophthalmos.

At the time of injury, there may be marked swelling of the soft tissues with haemorrhage and lid closure. Subconjunctival ecchymosis is usually present. The full extent of the injury is thus not obvious; however, subjectively, the patient may complain of diplopia early in the course of the illness. Where the clinical picture is clouded by ethanol, as is frequently the case in our experience, several days may pass before adequate subjective testing can be carried out.

Roentgenographic studies using body section technique are usually necessary to demonstrate the fracture site which may vary from a small fracture to a severe comminution with prolapse of orbital contents and tearing of maxillary sinus mucosa. Figure 1 shows a laminogram demonstrating such a "blow-out" fracture in a case of blunt trauma to the orbit. When the sinus is filled with blood from the trauma, the details of the fracture may be obscured.

Additional clinical signs may be present. With involvement of the infra-orbital nerve, anesthesia over its distribution is present. Following the decrease in edema and ecchymosis, enophthalmos becomes apparent. There is increase in depth of the superior palpebral sulcus which increases with time. Ptosis of the eyeball is present together with limitation of motion in the upper fields, especially if the orbital floor is severely comminuted and depressed.

Injury to the motor nerves of the inferior oblique and inferior rectus must also be considered. The inferior oblique is supplied by the inferior division of the third nerve which courses along the lateral border of the inferior rectus muscle to enter the inferior oblique in its middle portion. This nerve is exposed to injury; whereas, the relative short course of the nerve to the inferior rectus renders it less vulnerable to injury.

The management of "blow-out" fractures of the orbital floor is, in general, surgical. The findings of diplopia is important clinically, and in a few cases where there is fracture of the orbital floor without a great deal of displacement and no diplopia, surgical intervention is usually not necessary. However, when diplopia is present and the history is suggestive of "blow-out" fracture, surgical intervention is necessary even though X-ray findings may be inconclusive. The traction test gives a means of differentiating whether or not the inferior rectus muscle is incarcerated into the "blow-out" area and should be performed in all cases.

The orbital floor is exposed through an incision in the natural skin fold of the lower eyelid. The skin is undermined, exposing the orbicularis fibers which are then split and the rim of the orbital exposed. The periosteum of the orbital rim is then incised and reflected up so that the orbital contents are elevated. The site of the fracture is usually indicated by the herniated orbital tissues. These must be very carefully removed from the fracture site. This procedure may be facilitated in some cases by a Caldwell-Luc procedure into the maxillary sinus.

When the bones of the orbital floor can be put into good position, the sinus is then packed with gauze or some other type of mechanical tampon made in order to keep the roof in normal position. However, when the fragments are extremely comminuted, it is proper to use some type of graft over the fracture site just beneath the periosteum of the orbital floor. Many agents have been used such as glass wool, tantalum mesh, paraffin, acrylic wedges, etc. However, autogenous bone obtained from the superior iliac crest area is extremely useful for this type of procedure.

After the bone has been removed from the hip, it can be shaped to the desired size and configuration before it is placed beneath the periosteum. It is well to remember that the implant should not be too long in anterior-posterior dimension nor should it be too sharply pointed, as it is possible to injure the structures in the area of the orbital apex. Fine stainless wire anchors the bony implant to the orbital rim area. After the implant has been placed and anchored, it is usually noted that the ocular globe can then be freely rotated in all directions, indicating liberation of the inferior rectus and/or the inferior oblique muscle from the fracture site.

In old "blow-out" fractures of the orbital floor in which surgery was not done early, the repair is somewhat more difficult. Elevating the periosteum in an old scarred fracture area is complicated and in addition, there is alteration of the extraocular muscles,

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SPECIAL ARTICLES

The Physician and the Press†

KENNETH R. BYERLY*
Chapel Hill, N.C.

THE deep-rooted irritations between you of medicine and we of the news media are unfortunate, as we need each other. The public can also benefit if we work together.

You in medicine are important because you hold man's most priceless possessions—life and health—in your hands, but your public image isn't always good.

"The public misunderstands our true motives," an able physician once complained to me. "Our life-giving skills were developed by long and arduous preparation and we'd like to be thought of as generous, dedicated scientists to whom mankind owes some debt.

"We can't understand why we're not allowed full control over all circumstances in providing medical care, including financing and other non-medical aspects. We think the King-Anderson bill and related proposals to pay for personal medical care are schemes hatched by socialistic bureaucrats or well-meaning but addled eggheads.

"We physicians want and try to put our best foot forward," he concluded, "but fear we often put our foot in your mouth."

So you need the media's help and understanding.

"You're wrong," one of many physicians I once spoke to said, "when you say that half of us 'hate the guts' of newspapermen. We all do!"

Reporters are pictured as rough and tough, with callous indifference to people's feelings and a drive for sensationalism rather than accuracy. This image is usually false. Most newspapers try to avoid embarrassing anyone needlessly. I say "needlessly" because some stories that embarrass people must be reported anyway because of their nature.

Many reporters hide it under a rough veneer, but most have an affection and concern for people. I have never known a really good one who doesn't have the milk of human kindness in his heart, which is important to you in medicine.

I learned in 1948 why your late Senator Alben Barkley was one of the most loved and respected men in Congress. The then candidate for vice president arrived in our Montana community to make a major speech shortly before our afternoon daily's deadline.

"If I pick up your speech as you go along," I told him, "I won't have time to give it the news play it deserves. Could you give me the main points now so that I may write my story?"

He did in detail. Several hundred people were kept waiting. I was embarrassed and said so.

"Don't apologize," said Senator Barkley. "I'm here to get publicity for Harry Truman as a candidate for president of the United States, myself for vice president and for Montana Democrats who are running for Congress and state offices. You and your newspaper can give it to us, so I'm not doing you a favor when I take time to give you this information. You are doing us the favor. I am the one who should be grateful."

He was right!

Newspapers have great power to influence people, and I don't speak of editorials. I refer to the judgment they must use in deciding whether or not to run a story, the play or lack of play to give it through location in the paper and headline size, and the details included or omitted.

This power as newspapermen is no reason for us to shout and beat our chests. We should be humble instead, using it with decency, judgment and kindliness to help mankind. It is important to you in medicine that most experienced newspapermen have this philosophy, as we can and generally will work with you when there is reason to do so.

There is great reader interest in news stories on medicine, accidents and health. But it is often difficult for us to report them because of medical policies and fears that we sometimes think are archaic, inconsistent or even ridiculous. For example, what is your reaction to this story from a weekly newspaper?

> A physician's quick action saved the life of 3-year-old Mary Lou Martin on Sunday.
>
> She choked and lost consciousness, apparently from a throat swelling caused by illness.
>
> Mason L. Martin gave his daughter artificial respiration, but she had stopped breathing when Dr. George F. Watson arrived.
>
> The physician made an incision in the little girl's throat with a penknife while the father continued mouth-to-mouth respiration.
>
> She began to breath again so Dr. Watson finished the operation at the hospital . . .

†*Presented at the second General Session of the 1964 KMA Annual Meeting in Louisville, September 29, 1964.*

**Associate professor of journalism at the University of North Carolina School of Journalism, Chapel Hill.*

Physicians who see this think of their ethics rather than the reading public or the little girl's relatives and friends. Yet the story has great human interest and reflects credit on the physician and his profession. Readers want and should have such news.

Can't physicians and newspapers work together so that such stories may be told with a dignity that doesn't violate a sensible code. It would help medicine, the media and the public whose understanding and sympathy you need.

And doesn't a physician get the same warm glow from seeing his name in print favorably as do others?

There is no magic formula for developing better cooperation between medicine and the media. But people with newspapers, magazines, radio and television have the same pride, suspicions, egos, hopes and desires as others. So follow the Golden Rule when you deal with them: "Do unto others as you would have others do unto you."

We of medicine and the media really don't know each other, and this adds to our problems. "I've never known a man I didn't like," Will Rogers once said, so let's get acquainted.

If you know newspapermen and their problems, and give them a chance to understand you, they can and g e n e r a l l y will do a better and more sympathetic job for you.

"But," you say, "newspapermen must know that medicine is important. And they do, but they don't always understand and appreciate what you are doing.

Newspapermen are besieged by mail, telephone and in person by people and organizations who almost always think what they are doing is the most important and newsworthy. So they may overlook the real thing when it comes along, and yours is often the real thing.

So talk to your publisher, editor or reporter.

Don't take it for granted that he knows what you are doing.

Don't assume that he understands and appreciates it, as he often doesn't.

And, above all, *Don't* have a chip on your shoulder.

You must impress him . . . *Explain* . . . be patient. But *Don't* take 60 minutes to tell him what you should in six.

Don't give him a lot of guff and hot air.

And please don't just growl about newspapermen and women and say they are against you. They aren't.

They must understand your problems to report them, accurately or at all.

This approach w o r k e d at Spartanburg, South Carolina, where relations between physicians and the press had not been good (which probably hurts medicine more than the press, though medics seldom realize this).

Managing editor Bob Craig said the *Spartanburg Journal* "tried hard to get news stories on medical developments, but with little success, so found ourselves reporting most of the bad news on medicine and little of the good.

"For example, a story on a physician who used hypnosis when delivering babies fell through because the medical profession wouldn't let us use his name. But a physician charged with drunken driving was named in the paper because it was public record."

This slanted news against physicians through no fault of the paper, so the concerned editor explained the problem to physician friends.

"They never really understood their disadvantage," he said, "until a crisis at the county hospital resulted in dozens of news stories, with the medical profession getting the short end in public relations.

"The solution came from the physicians," the South Carolina editor said. "They discussed ways to better their image, decided to cooperate with the press wherever possible, and then approached the newspapers to say so."

The new understanding and cooperation between medicine and the press has helped both greatly, and the public.

A newspaper that comes out editorially for such things as medicare seldom closes its columns to doctors who wish to state their case.

"Doctors over-estimate the power of editorials," a top newspaperman told me. "News stories and features are far more persuasive with most readers. A newspaper's letters to the editor column probably has as much weight as editorials and certainly more readers, but doctors seldom take advantage of this opportunity."

Another able news executive said that medical associations "adopt resolutions against things like medicare and we carry the news. But they are usually against things, and I don't think the negative attracts the attention of readers and editors like the positive.

"Doctors can better promote a good image by giving us stories on things like their emergency call plans, grievance committees and the like. But they are reluctant to publicize the good things they do."

"Above all," a medical reporter told me, "many doctors need understanding of human needs . . . the size of their bills, long waits in doctors' offices, and their too frequent failure to explain things to people . . . such things affect a doctor's public relations more than anything else."

Some of you may lack confidence in certain reporters . . . fear you may be embarrassed or even sued because of careless reporting. This is another reason to talk to media people.

Doors open wider on touchy and technical subjects when I say first to the physician and others, "May I check my story with you to make sure there are no mistakes?"

Don't try to rewrite a reporter's story if he says this to you as he'll quite rightly resent it. Check it for technical accuracy only.

If you are worried and a reporter makes no such offer, there is no harm in suggesting tactfully that the subject is "complicated and technical, so call me if you wish after you have written your story as I may be able to help us both."

And don't insist on technical jargon as did a science professor at the University of North Carolina against the advice of our News Bureau director, Pete Ivey. No newspaper used the story, but one sent it

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EDITORIALS

Welcome Among Us

NEXT month there will graduate from our medical schools more than 8,000 young physicians. They will enter our hospitals as interns and during the next year of formal medical training, they will be more or less under the observation and supervision of private practicing physicians. They will receive from this association new and different impressions than they gained while in medical school. Their attitude toward medical practice and their decision regarding the course that they are to follow during their professional lives will be thus greatly influenced. It will be well if we seasoned and mature physicians give to these young men the best that we have in professional and ethical training.

An equal number who received their M.D. degree a year ago will complete their internship and either enter directly upon their chosen field of practice or will continue residency training in some selected specialty. The cordial and friendly welcome which we accord these young physicians and the help that we may offer them in starting their practice or in pursuit of their specialty training is bound to influence them favorably throughout their professional life.

It is stimulating and helpful to interns and residents when the County Medical Society encourages them to join as associate members, either complimentary or with nominal dues. They appreciate the privilege of attending and participating in our scientific programs and social activities.

The comradeship that is observed among musicians might well be an example to us as physicians. I have seen an 80 year old cellist whose leading passion in life was his music. He had gained an enviable reputation for his skill and faithfulness by his performance in local orchestras and smaller musical groups. It was inspiring to watch the intensity and care with which he bent over his music with dimming vision and spectacles that did not well compensate and fingered his cello with hands that were stiffened with arthritis. He still made good music and kept beautifully in harmony with the orchestra, which accomplishments filled him with pride. Beside him played a youth of about twenty. The comradeship of music which bound these two men so closely was beautiful to see. The older man was lavish in his praise and admiration for the youth who with better training and nimble fingers could produce softer and more melodious strains of music than he.

There should ever be such a comradeship in the conduct of our daily affairs. We must readily admit that the younger physician with his superior educational background and his longer and improved period of graduate training brings to medicine a new approach and skills that the older physician is often unable to match. We may give him much in the way of friendship, encouragement, and experience, but we must admit that he has much to offer in return. It is well if we work in the closest cooperation and comradeship.

This year there will come to the United States 7,000 or more foreign trained physicians. They come to learn our methods and to share in the advances that American medicine has achieved during the past generation. The primary and most desirable objective of this exchange is that these physicians learn our methods and techniques and carry new skills back to their own people who are less favored than we. By such an exchange we have a unique opportunity to spread good will and understanding among our neighbors of this hemisphere and on every continent. We may well, therefore, exert ourselves to teach and train these men as best we can.

To one visiting or living in a foreign country no form of hospitality is so valuable or more highly prized than the opportunity to visit in

the homes and participate in scientific activities and the cultural and recreational practices of his host. This, added to the medical training provided, often proves to be the key to friendship, understanding, and appreciation.

Some foreign trained physicians will remain in this country if possible because they appreciate the economic advantages which may not be available in their home state. While this is not the original objective of our foreign training program, it has often in the past resulted in vast improvement of our own methods and accomplishments. We must not forget that Hideyo Noguchi, Sir William Osler, Anton J. Carlson, Albert Einstein, and a host of other eminent scientists came to us either for training or for refuge, and their lives and work in the United States greatly enriched and extended our own scientific advances.

Some will come poorly prepared in spite of our effort to approve or disapprove foreign medical schools and establishing the ECMFG certification as a credential for admission. A few unhappy experiences occur every year. For these impositions we must be constantly vigilant; but the good fruits of the foreign training experiment so far outweigh the unfavorable effects that we cannot complain too bitterly about the isolated unfortunate experiences that we have had.

We believe that we have the best system of medical services throughout the world. We are happy that physicians from all over the world come to learn and share our methods. It will not continue, however, without a spirit of tolerance, of companionship and cooperation.

SAM A. OVERSTREET, M.D.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater leadership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.



JOSHUA BELL LUKINS

Joshua Bell Lukins, M. D.

1881—1965

ON 25 March 1965, Dr. Joshua Bell Lukins died following a long illness. Thus closed a long and unselfish career of public service to the civic as well as the medical community of Kentucky and Jefferson County.

Doctor Lukins was born at Mount Carmel, Fleming County, on 4 November 1881. After receiving his preliminary education in the Mt. Carmel school and the Flemingsburg High School, he taught school for several years in Fleming County. He then came to Louisville and attended the Hospital College of Medicine from which he received his M.D. in 1906. Following an internship at the Louisville City Hospital, he entered the general practice of medicine. Soon after beginning practice he became a member of the part-time faculty of the University of Louisville School of Medicine as Adjunct Professor of Obstetrics (1909-1916). In 1916 he became Lecturer in Gynecology. During World War I he served as a medical officer in the Army. Following his return to civilian status, he served as a house officer at Bellevue Hospital, New York (January-March 1919).

After his return to Louisville he was appointed Adjunct Professor of Gynecology and Obstetrics. He maintained an active association with the Medical School faculty until he retired as Associate Clinical Professor of Obstetrics and Gynecology in 1948.

In addition to a busy private practice in general surgery, Doctor Lukins devoted much attention to our county, state, and national medical societies, the Kiwanis Club, and the Fourth Avenue Methodist Church. He served faithfully and with distinction as Chairman of the Medico-Legal Committee of the K.M.A. for 31 years, and as a member of the A.M.A. Judicial Council for a number of years. From 1943-1951 he also served as K.M.A. delegate to the A.M.A.

During the year 1924, Doctor Lukins was President of the Jefferson County Medical Society, and he continued throughout his nearly 50 years of active practice to serve this Society in various capacities.

In 1935 Doctor Lukins was honored by being elected President of the Kentucky Medical Association. Recognizing the continued services of Doctor Lukins, the K.M.A. awarded him the annual award for Outstanding Service to Organized Medicine in 1951, and the K.M.A. Annual Distinguished Service Award in 1955.

Doctor Lukins was a Fellow of the American College of Surgeons, and a former vice-president of the Southeastern Surgical Congress. His nearly two dozen publications in medical periodicals are primarily concerned with special problems in obstetrics and gynecology.

Doctor Lukins was an active member of the staff of the Deaconess Hospital, and when plans were formulated for the construction of the Methodist Evangelical Hospital, he was appointed co-chairman of the Doctor's Division of the 1957 Fund drive for its construction. Through his efforts and those of his colleagues, a large subscription was obtained. The success of the campaign was a great personal satisfaction to Doctor Lukins and his last great effort in behalf of the improvement of the medical and civic community of Louisville.

Doctor Lukins served his fellow man unselfishly and he will be remembered for his services and missed by his many colleagues.

ORGANIZATION SECTION



Doctor Beecham



Doctor Howland

Top Guest Lecturers on Program Of Annual Meeting Sept. 21-23

Sixteen guest speakers of national prominence in their respective medical fields will participate in the scientific program of the 1965 KMA Annual Meeting in Louisville September 21-23, according to Delmas M. Clardy, M.D., KMA president and chairman of the Council on Scientific Assembly.

In releasing preliminary information on the program, Doctor Clardy stated that, "An outstanding postgraduate education program has been planned for this year's meeting, combining excellence of speakers and scientific material with splendid convention facilities."

One feature of the scientific program, said Douglas M. Haynes, M.D., Louisville, chairman of the scientific program Committee, will be a Telephone Party Line Conference on heart disease between three top medical authorities and two local panelists. Participants have not yet been selected. This session, as well as all other scientific sessions, will be held in the Convention Center.

Names and background information on three of the guest speakers for the Annual Meeting were released recently by Doctor Clardy. Additional program information will be carried in subsequent issues of The Journal.

Clayton T. Beecham, M.D., Danville, Pa., director of gynecology and obstetrics at Geisinger Medical Center, Danville, will be the guest of the Kentucky Obstetrical and Gynecological Society, and will address his hosts on Tuesday afternoon, September 21, on a topic not yet announced. "Management of Endometriosis" will be Doctor Beecham's subject when he speaks at the general scientific session on Wednesday mornir g, September 22.

Doctor Beecham is secretary of the American Association of Obstetricians and Gynecologists, and chairman of District III, The American College of Obstetricians and Gynecologists. He is a member of the Society of Pelvic Surgeons and the co-author of a textbook entitled "Obstetrics and Gynecology". He is a 1933 graduate of the University of Minnesota Medical School, Minneapolis.

William S. Howland, M.D., New York City, will be the guest of the Kentucky Society of Anesthesiologists. He is head of the section on experimental anesthesiology at Sloan-Kettering Institute. Doctor Howland will speak before his hosts on Tuesday afternoon, and at the general scientific session on Tuesday morning. The subjects of his presentations will be announced later.

Doctor Howland, who has served on the medical faculties of Cornell University and Columbia University, is president-elect of the New York State Society of Anesthesiologists, and was a vice-president last year. He is chairman of the Anesthesiology Section of the New York State Society of Medicine. Doctor Howland, a Fellow of the American College of Anesthesiologists, was awarded his medical degree in 1944 by the Columbia University College of Physicians and Surgeons.

The guest of the Kentucky Academy of General Practice, Jackson A. Smith, M.D., is professor and chairman of the department of psychiatry and neurology at Stritch School of Medicine, Loyola University, Chicago. His topic at the Wednesday afternoon general scientific session will be "Who is an Alcoholic?" The following afternoon, the KAGP will hear a presentation by Doctor Smith entitled, "Are *You* A Psychiatrist."



Doctor Smith

He served from 1959 to 1964 as clinical associate professor of psychiatry at the University of Chicago, and as clinical director of Illinois State Psychiatric Institute. He has also been on the medical faculties of Baylor University and the University of Nebraska. Doctor Smith was director of research of the Nebraska State Mental Health Program from 1955-59. He is a 1943 graduate of the University of Oklahoma School of Medicine.

Preliminary Program Released For 1965 Annual Meeting

The preliminary program outline for the 1965 KMA Annual Meeting, to be held September 21-23 at the Convention Center in Louisville, has been released by

Delmas M. Clardy, M.D., KMA president and chairman of the Council on Scientific Assembly.

The full program, plus information on all speakers, will be published in later issues of The Journal. The tentative basic program follows:

Tuesday, September 21

Morning Session

Edith Potter, M.D., Chicago, Ill.,—*"Abnormal Development of the Ovary as it May Affect Ovarian Function in the Adult"*

William S. Howland, M.D., New York, N.Y.,—Topic to be announced

Panel Discussion—*"Respiratory Distress in the Newborn"*—Walter T. Hughes, M.D., Louisville, Moderator

Afternoon Session

Eight of the 16 cooperating specialty groups will hold their scientific sessions on Tuesday afternoon. There will be no general scientific session at that time.

Wednesday, September 22

Morning Session

Thomas D. Brower, M.D., Lexington, Ky.—Topic to be announced

Richard Chute, M.D., Boston, Mass.—*"Bacteriuria and Pyloneplritis"*

Theodore E. Logan, D.D.S., Louisville, Ky.—*"Prevention of Serious Injuries — Mouthguards for Athletes"*

Clayton T. Beecham, M.D., Philadelphia, Pa.—Topic to be announced

Afternoon Session

Telephone Party Line Conference (Tele-Lecture)—Walter S. Coe, M.D., Louisville, Moderator

Arthur C. Curtis, M.D., Ann Arbor, Mich.—Topic to be announced

Jackson A. Smith, M.D., Hines, Ill.—*"Who is an Alcoholic?"*

Joseph H. Ogura, M.D., St. Louis, Mo.—Topic to be announced

Thursday, September 23

Morning Session

Leonard M. Schuman, M.D., Minneapolis, Minn.—Topic to be announced

H. Marvin Pollard, M.D., Ann Arbor, Mich.—*"Late Complications of Gastric Surgery for Peptic Ulcer"*

Panel Discussion—*"Peptic Ulcer"*—Edmund D. Pellegrino, M.D., Lexington, Ky., Moderator

Afternoon Session

No general scientific session has been scheduled for Thursday afternoon. Eight specialty groups will meet at that time, one of which will begin Thursday morning.

GPs Choose Dr. Witten to Head American Academy in 1966-67

Carroll L. Witten, M.D., Louisville, was named April 12 as president-elect of the American Academy of General Practice during the organization's 1965 annual meeting in San Francisco. He had served five years as speaker of the AAGP Congress of Delegates.



Doctor Witten

Doctor Witten is former chairman of the Kentucky Medical Association's School Health Committee, and a former delegate from the Jefferson County Medical Society to KMA, as well as other assignments within KMA. He is currently a delegate to the AMA from the Section on General Practice.

Last May he was chosen president-elect of the Kentucky Academy of General Practice, and is a past president of the Jefferson County Academy. The KAGP in 1959 named Doctor Witten "family doctor of the year."

A 1951 graduate of the University of Louisville and a veteran of World War II, Doctor Witten is also a member of the U.S. Surgeon General's Advisory Committee on Indian Health, and is active in other medical and civic activities on local and state levels.

MEDICAL SCHOOL NEWS

U. of K. Begins Work on Center For Clinical Research

Work on a $179,800 general clinical research center—one of 82 throughout the country and the first of its kind in the state—began in March at the University of Kentucky Medical Center.

The center will be housed in the remodeled fifth floor north wing of the Medical Center, which until recently was used as a 28-patient ambulant ward. The research center, when completed, will include complex equipment, a metabolic kitchen, its own nursing station, laboratories, and will have a capacity for ten patients.

Research to be conducted there will include studies ranging from normal heart activity to physiology in severe trauma cases, conducted by physicians from all departments of the Medical Center. E. D. Pellegrino, M.D., chairman of the U.K. department of medicine, will be in charge of the unit. The Clinic will be directed by William W. Winternitz, M.D., and E. Douglas Rees, M.D.

Ky. College of Surgeons Elects Dr. Edelen New President

Charles M. Edelen, M.D., Louisville, was elected president of the Kentucky Chapter of the American College of Surgeons April 10 during the closing session of the Chapter's two-day annual meeting in Paducah.

He succeeds Robert W. Robertson, M.D., Paducah, as president. Also elected were: Lawrence M. Quill, M.D., Newport, vice-president, and David Hull, M.D., Lexington, secretary-treasurer. Burton Washburn, M.D., Paducah, was named to the chapter council, replacing Robert Pennington, M.D., London, whose term had expired.

Approximately 75 physicians and their guests registered for the meeting, held at the Holiday Inn in Paducah April 9 and 10. Next year's meeting will be held in Lexington. No date has been set at this writing.

Dr. Simpson Appears on Program At Rural Health Conference

Gaithel L. Simpson, M.D., Greenville, at the invitation of the American Medical Association, participated in a panel discussion at the 18th National Conference on Rural Health March 26 at Miami Beach, Fla.

Doctor Simpson, former KMA president and chairman of the Governor's Advisory Council on Indigent Care in Kentucky, took part in a discussion of the implementation of the Kerr-Mills program.

Also representing Kentucky at the meeting was Donald L. Graves, M.D., Frenchburg, chairman of the KMA Rural Health Committee.

Ky. Ob-Gyn Elects Dr. Woolsey

Elwood L. Woolsey, M.D., Harlan, was elected president of the Kentucky Obstetrical and Gynecological Society during the group's annual meeting held April 1-2 at the University of Kentucky Medical Center, Lexington.

Also elected were Francis A. Forde, M.D., Middlesboro, president-elect, and Joseph F. Daugherty, M.D., Florence, secretary. The program this year was held in conjunction with the U.K. department of radiology's Symposium on Genito-Urinary Disease.

Hospital Costs Booklet Published By Ky. Chamber of Commerce

A booklet recommending steps for cutting down the rising costs of hospital care has been published by the Kentucky Chamber of Commerce in cooperation with the Kentucky Medical Association, Kentucky Hospital Association, Kentucky Department of Health and the Louisville Chamber of Commerce.

Information in the publication includes practical matters such as hospital utilization, out-patient services, hospital services to patients in the home, convalescent facilities, cost control programs, and community planning in hospital construction.

The 12-page booklet, directed toward hospital trustees and administrators, physicians and individual potential hospital users, is available from the office of the Kentucky Chamber of Commerce, Third and York Streets, Louisville, Ky., 40202.

U. of K. Senior Day Program Features Talks, Dinner

A dinner given by the Fayette County Medical Society for senior students from the University of Kentucky College of Medicine climaxed the program of the second annual KMA Senior Day program at U. K. April 13.

The dinner, held at the Imperial House in Lexington, was arranged under the direction of T. R. Bryant, M.D., president of the Fayette County Society, and John F. Berry, M.D., secretary.

Delmas M. Clardy, M.D., Hopkinsville, KMA president, and William K. Keller, M.D., professor and chairman of the department of psychiatry at the University of Louisville, were featured speakers on the program, arranged by KMA in cooperation with the Fayette County Society and the College of Medicine. Carl Cooper, M.D., Bedford, chairman of the KMA Senior Day Committee, was in charge of the program.

National Hospital Week Set For Observance May 9-15

Kentucky physicians are being asked by the American Medical Association and KMA to participate in the observance of National Hospital Week May 9-15 and in the many attending local programs that may be scheduled in their communities.

The theme of the program, "People—Heart of the Hospital," was selected to focus attention on the important human element in patient care, to foster good morale among hospital employees and volunteers, and to encourage young people in the community to consider a hospital career.

National Hospital Week is sponsored each year by the American Hospital Association for the purpose of acquainting the community with its hospital.

KAGP Plans Seminars in June

The Kentucky Academy of General Practice has announced the dates of two June Seminars to be held at Harrodsburg and Henderson. The Harrodsburg meeting, set for June 10, will be held at Beaumont Inn, according to Charles W. Sisk, M.D., Danville, chairman. June 24 is the date of the Henderson Seminar, Kenneth M. Eblen, M.D., Henderson, chairman for that meeting, announced. More information will appear later on these meetings.

Recommended Dosage of Lomotil Liquid to Control Diarrhea

File: Diarrhea

LOMOTIL®

Age	INITIAL LOMOTIL LIQUID DOSAGE*
3-6 mo.	½ tsp. t.i.d. (3 mg.)
6-12 mo.	½ tsp. q.i.d. (4 mg.)
1-2 yr.	½ tsp. 5 times daily (5 mg.)
2-5 yr.	1 tsp. t.i.d. (6 mg.)
5-8 yr.	1 tsp. q.i.d. (8 mg.)
8-12 yr.	1 tsp. 5 times daily (10 mg.)
Adult	2 tsp. 5 times daily (20 mg.) (or 2 tablets q.i.d.)

*Based on 4 cc. per average teaspoonful.
Note: After diarrhea is controlled the initial dosage can usually be reduced to meet the requirements of the individual patient.

LOMOTIL® TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

Precautions
Lomotil is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Cautions and Side Effects
Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*

Dinner, Talks Highlight Program At KMA Senior Day at U. of L.

"The Great Society of Mediocrity" was the topic of Delmas M. Clardy, M.D., KMA president from Hopkinsville, one of many speakers who addressed U. of L. senior medical students at the 11th annual KMA Senior Day March 11.

A dinner that evening, at which individual members of the Jefferson County Medical Society hosted the students, was held at the Medical Arts Building, according to Roy H. Moore, M.D., Society president. The entire program was arranged by KMA in cooperation with the County Society and the medical school.

Other speakers discussed topics of interest to the student soon to enter practice. Carl Cooper, M.D., Bedford, KMA Senior Day Committee chairman, was in charge of arrangements.



PAST, PRESENT AND FUTURE presidents of the Kentucky Hospital Association posed for the photographer during the March 29-April 1 annual meeting of the KHA in Louisville. From left are Ben R. Brewer, immediate past president and administrator of Western Baptist Hospital, Paducah; W. Leon Hisle, president, administrator at Berea College Hospital, Berea; and Randall C. Eli, president-elect from Ashland, administrator at District 4 State TB Hospital.

Randall C. Eli Will Head Hospital Assn. in 1966

Randall C. Eli, administrator of District Four State Tuberculosis Hospital at Ashland, was chosen president-elect of the Kentucky Hospital Association at the close of the March 29-April 1 annual meeting at the Kentucky Hotel in Louisville.

Mr. Eli will take office in 1966, succeeding W. Leon Hisle, Berea College Hospital administrator, who was installed as 1965 president during the Louisville meeting.

A native of Owensboro, Mr. Eli received an A.B. degree in business administration from Centre College in 1950. From 1950 until accepting his current post at Ashland in 1952, he was assistant administrator of District One Tuberculosis Hospital at Madisonville.

Kentucky Governor Edward T. Breathitt and Doctor Norman Vincent Peale, minister at Marble Collegiate Church in New York City, were featured speakers at the meeting.

A record-shattering 1,647 persons attending the four-day program which featured sessions on Nursing and Unionization Trends, and seminars on the "Mandatory Nurse Practice Act," "Pharmacy Legislation Affecting Hospitals," and "Hospital-Employee Contractual Relationships."

Dr. Boldrick, Owensboro, Named To Head Ky. Dental Assn.

Thomas J. Boldrick, D.D.S., Owensboro, was named president-elect of the Kentucky Dental Association on April 4 as the KDA's 105th annual meeting began at the Brown Hotel in Louisville.



Doctor Boldrick

Thomas H. Schuler, D.D.S., Covington, was installed as president of the association, succeeding R. Burke Coomer, D.D.S., Louisville.

Doctor Boldrick, a native of Springfield, Ky., graduated in 1937 from St. Louis Dental College and has practiced in Kentucky since that time, with the exception of three years' service in World War II. He is a past president and former secretary of the Green River Dental Society and has served on a number of KDA committees.

Maynard K. Hine, D.M.D., Indianapolis, president-elect of the American Dental Association, one of the featured speakers on the KDA annual meeting program, said in comment on health legislation that the ADA "has been and continues to be unequivocally opposed to any measure which would provide health care to a segment of the population without regard to need."

Other officers elected during the meeting included A. J. Zechalla, D.D.S., Covington, and L. S. Coblin, D.D.S., Louisville, both vice-presidents. The KDA also announced tentative plans for the construction of a headquarters office in or near Louisville's Medical Center.

Ky. C. of C. Elects President

Grant McDonald, Lexington, vice-president of Square D Company, was elected president of the Kentucky Chamber of Commerce April 12 at a meeting of the Chamber's Board of Directors in Owensboro.

Among other officers named were: John W. Woods, Jr., Ashland, first vice-president; Leroy M. Miles, Lexington, treasurer; and James C. Zimmerman, Louisville, executive vice-president. Gaithel L. Simpson, M.D., Greenville, a member of the Board of Directors of the Kentucky Chamber, attended the meeting, along with other KMA members.



and in previously treated
pertensive patients...



Uh-huh.



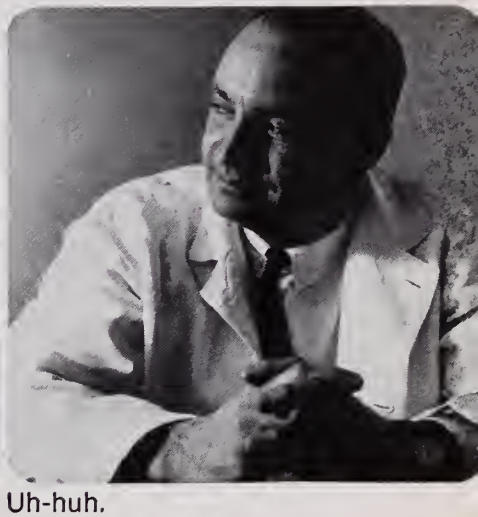
Regroton improved response
in 76 out of 80...



n-huh.



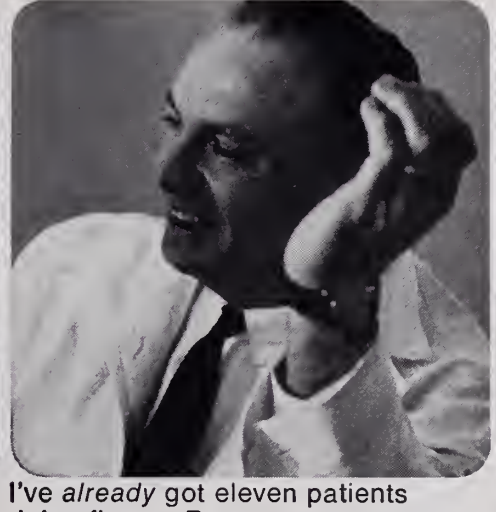
...reducing mean arterial pressure
from 135 to 112 mm. Hg.



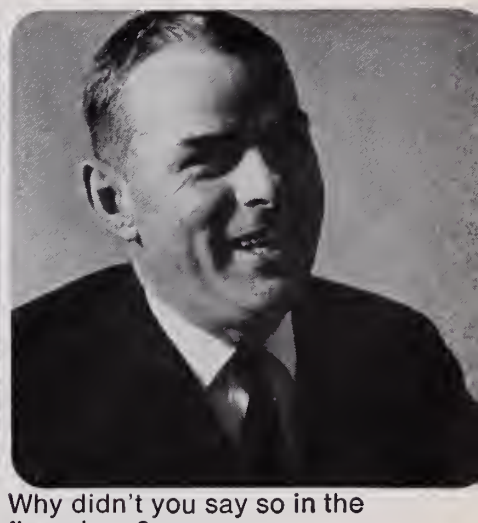
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cautions: Reduce dosage of concomitant anti-ertensive agents by one-half. Discontinue if BUN rises or liver dysfunction is aggravated. ctrolyte imbalance and potassium depletion severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
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Average Dosage: One tablet daily with breakfast.
Availability: Bottles of 100 and 1000 tablets.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

Geigy Pharmaceuticals
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Dr. Porterfield is New Director Of Accreditation Commission

John D. Porterfield, III, M.D., coordinator of medical and health services at the University of California at Berkeley, was named April 1 as director of the Joint Commission on Accreditation of Hospitals, it was announced by Richard A. Kern, chairman of the Commission.

Established in 1952 by physicians and hospitals to constantly evaluate hospital care standards throughout the nation by voluntary methods of self discipline, the Commission for the past ten years has been directed by Kenneth E. Babcock, M.D., whose resignation was announced last April.

The hospital standardization program was originated in 1919 by the American College of Surgeons and was carried out by that organization until the Commission was formed in 1952. The Commission is composed of four member associations, including the ACS, the American Medical Association, the American College of Physicians, and the American Hospital Association.

U. of K. Anesthesia Dept. Holds Respiratory Problem Course

The anesthesiology department at the University of Kentucky Medical Center will sponsor a one-day post-graduate course on acute and chronic respiratory problems on Saturday, June 12. The program will consist of formal presentations by faculty members, interrupted by discussion.

The afternoon session will be devoted to individual practice demonstrations of the use of several mechanical ventilators with emphasis on the application of these techniques to acute and chronic respiratory problems. The program will be concluded with a panel discussion on problems associated with the management of such things as tetanus and barbiturate intoxication.

All Kentucky physicians are cordially invited to attend the meeting. Application has been made to the AAGP for credit. Those interested may contact M. A. Carnes, M.D., Dept. of Anesthesiology, University of Kentucky Medical Center, Lexington, Ky., 40506.

Dr. Willard's Portrait Unveiled

Now hanging in the student lounge of the U. of K. medical center is a new portrait of William R. Willard, M.D., vice-president of the university and dean of the medical school, which was unveiled Saturday, April 17.

The portrait was presented by 14 friends of the vice-president and unveiled at ceremonies presided over by University president John W. Oswald.

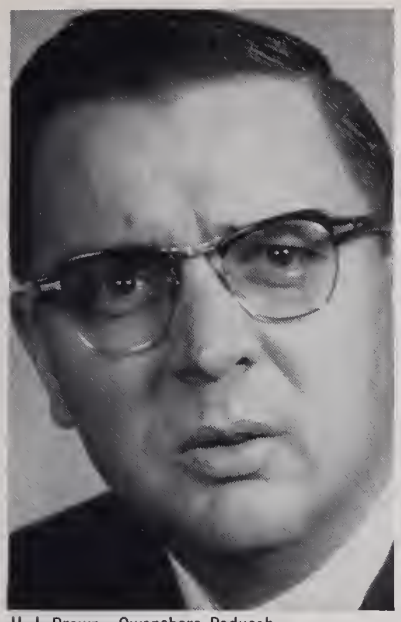
Dr. Rash Marks 68th Anniversary

O. W. Rash, M.D., Owensboro surgeon now in general practice, marked the 68th anniversary of his medical career on April 6. Doctor Rash, who is 88, attended Louisville Medical College for two years, and was graduated from Bellevue Hospital Medical College in New York City.

He retired from surgery at the age of 73, but still maintains a general practice. The Kentucky Medical Association presented Doctor Rash with a 50-year service medal in 1950, and he was honored by the Daviess County Medical Society last year.



AMA-ERF CHECKS TOTALING $15,264.84 were recently presented to Kentucky's two medical schools by representatives of the Kentucky Medical Association on behalf of the American Medical Association Education and Research Foundation. In the picture at left, Delmas M. Clardy, M.D., Hopkinsville, KMA president, presented a check for $4,359.57 on April 13 to William R. Willard, M.D., light suit, dean of the U.K. College of Medicine. At right Dean Donn L. Smith, M.D., of U. of L., accepted a check on April 19 for $10,905.27 from Walter I. Hume, M.D., Louisville, far right, chairman of the KMA AMA-ERF Committee.



H. J. Brown—Owensboro-Paducah



J. B. Darland—Covington



R. A. Schehr—Louisville

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NEWS ITEMS

J. Farra Van Meter, M.D., Lexington surgeon, was recently given the downtown Lexington YMCA's 1964 Red Triangle award for "personal leadership over many years of service." The service award was one of several made during an annual dinner meeting of the Greater Lexington YMCA.

Ralph J. Angelucci, M.D., Lexington, was reappointed March 22 as a trustee of the University of Kentucky for a term expiring in 1968. Doctor Angelucci is a neurologist and psychiatrist.

Edward C. Bowling, Jr., M.D., a general surgeon, has opened an office at Stanford, it was recently announced. Doctor Bowling, who graduated in 1952 from the University of Louisville School of Medicine, interned at St. Anthony Hospital and completed his residency training at the Veteran's Hospital in Louisville. He formerly practiced at Lebanon and at Brooksville, Fla.

Keene A. Watson, M.D., has joined the staff of the University of Kentucky School of Medicine's department of community medicine. A 1947 graduate of Vanderbilt University College of Medicine, he interned at Rochester, N.Y., General Hospital and was a general practice resident at State University of Iowa Hospitals. He formerly practiced in the Belgian Congo.

Wilmier M. Talbert, Jr., M.D., is a new member of the department of pathology at the University of Kentucky, it was recently announced. Doctor Talbert graduated in 1956 from Washington University School of Medicine in St. Louis and interned at Barnes Hospital. His residency was completed at Jackson Memorial Hospital, Miami. Doctor Talbert was in practice at Ft. Meyers, Fla., for a short time.

Brian P. Geoghegan, M.D., is now in practice at Lexington, where he is a member of the staff of the pathology department at Good Samaritan Hospital. Doctor Geoghegan received his medical degree at the Royal College of Surgeons in Dublin in 1957, and interned at Charity Hospital, Buffalo, N.Y. Following the completion of his residency training at Mercy Hospital, Des Moines, Ia., in 1962, Doctor Geoghegan practiced in Des Moines.

Philip R. Rothrock, M.D., is now associated with **S. H. Reid, M.D.,** at Danville, where he will practice general medicine. Doctor Rothrock, a 1961 graduate of the University of Louisville School of Medicine, interned at Sts. Mary and Elizabeth Hospital in Louisville. He previously practiced at Kingsport, Tenn.

James Harris, M.D., Paducah urologist, was recently elected president of the Paducah Rotary Club for a term beginning July 1. A graduate of Duke University School of Medicine, he has been in Paducah for five years.

Max P. Jones, M.D., Pikeville, has been named a diplomate by the American Board of Internal Medicine, according to a recent report. A 1944 graduate of the University of Louisville School of Medicine, Doctor Jones completed his training at the University of Iowa Hospitals. His practice at Pikeville is limited to internal medicine.

John Snowden, M.D., Winchester, was recently awarded a 50-year Masonic Membership pin by the Winchester Lodge No. 20 F. & A.M. A program entitled "This is your Life" was presented in his honor. Doctor Snowden began practice at Winchester in 1908 and retired in 1958.

James Blanding, Jr., senior student at the University of Kentucky College of Medicine, received an honorable mention cash award of $50 and a plaque for his entry in the fifth annual Student American Medical Association—Mead Johnson Scientific Forum. Mr. Blanding is from Lexington.



The Seventh Anual luncheon for University of Louisville Senior medical students at the Blue Shield-Blue Cross building in Louisville was arranged with the University by Hoyt D. Gardner, M.D., professor of medical civics, shown standing at microphone in right rear. After the luncheon and a tour of the Blue Shield-Blue Cross Building, the students visited the KMA Headquarters office, where they were escorted through the building. A similar dinner meeting was held in Lexington for the Seniors at the University of Kentucky after the deadline for this issue of The Journal.

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Committee on Scientific Exhibits

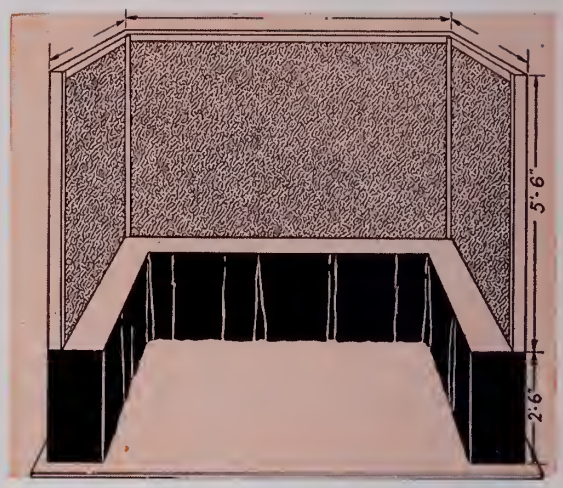
Kentucky Medical Association

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Louisville, Kentucky 40205

Applications for space should be received before July 1, 1965

Dimensions and structure of KMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit:
2. Name (s) of Exhibitor (s): (AMA Member?)

 Institution (if desired):

 Mailing Address
3. Do you have a built-in exhibit?
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)

 Charts and Posters.... Photographs.... Drawings X-rays....

 Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:

 Amount of wall space needed?

 Back wall Side walls (All side walls are 4')

 Square feet needed? Shelf desired? (yes or no)
7. Indicate sources of assistance provided in connection with the exhibit.
8. Has this exhibit been exhibited before? If so, when & where?

Date

Signature of Applicant

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.



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*Heredia Diaz, J. et al.: Medicina (Mex.) 38:308, July 10, 1958.

Condition	No. of Patients	No. Responded to Signemycin
Abortion, infected	45	44
Adnexitis (parametritis)	66	61
Cervicitis	18	18
Endometritis	64	61
Mastitis and breast abscess	44	42
Puerperal sepsis	14	14
Salpingitis	39	34
Other ob-gyn infections	51	46
Totals	341	320 (93.8%)

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Brief Summary and Bibliography follow.

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Cardiac Course Set at U.K.

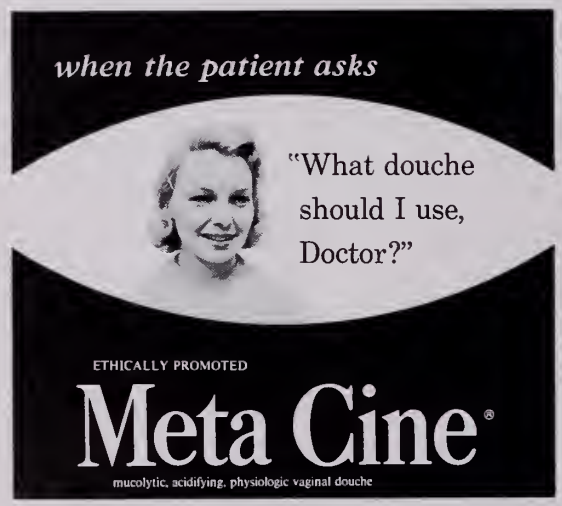
Two Cincinnati Cardiologists will be the featured guest speakers at the two-day symposium on Cardiac Emergencies to be held May 13-14 at the University of Kentucky Medical Center, according to Nicholas J. Pisacano, M.D., director of continuing education at the College of Medicine.

Noble O. Fowler, M.D., professor of medicine, and Thomas Gaffney, M.D., associate professor of medicine, both at the University of Cincinnati, will present individual papers and take part in group discussions during the meeting. A registration fee of $20 for the two day session is required. Enrollment will be limited.

Eleven New KMA Members Listed

Eleven physicians are new members of the Kentucky Medical Association, according to membership records dated April 14. Among those listed are Herman Pocock, Jr., M.D., Jo Ann Sexton, M.D., and John D. Winebrenner, M.D., all of Louisville.

Others are: James E. Anderson, M.D., Edwin H. Hanekamp, M.D., Carroll E. Howard, M.D., John A. McKay, M.D., and William E. Pearson, M.D., all of Owensboro. Also listed are: E. John Fales, M.D., and James V. Grief, M.D., of Covington, and Edward Martin, Jr., M.D., Frankfort, and Glen D. Richards, M.D., Lewisport.



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NEWS ITEMS

L. Chase Allen, M.D., Lexington, has started the practice of plastic, reconstructive and hand surgery in that city. Doctor Allen, a native of Jackson, received his M.D. degree in 1958 from the University of Louisville School of Medicine, and interned at Orange Memorial Hospital, Orlando, Fla. He completed his residency training at the Indiana University Hospitals.

Juan R. LaCerda, M.D., has become associated with **Glenn L. Pfister, M.D.,** Ft. Thomas, where he will limit his practice to surgery. Doctor LaCerda, a native of Cuba, received his medical degree from Havana University Medical School and interned at Union Hospital, Fall River, Mass. He completed his residency training at Jewish Hospital, Cincinnati.

James E. Adams, M.D., Providence, has begun general practice in association with the Trover Clinic, it was recently announced. Doctor Adams, a 1960 graduate of the University of Louisville School of Medicine, interned at Baptist Memorial Hospital, Memphis, Tenn. From 1961-1964 he served as a general medical officer in the U.S. Army.

Milton Green, M.D. returned to Henderson April 15 to take the post he formerly held as health officer for the area. Doctor Green left Henderson in September, 1964, to assume private practice at Hopkinsville. **J. Leland Tanner, M.D.,** Henderson, served as medical advisor during Doctor Green's absence.

Richard E. Bibb, M.D., Cincinnati, a psychiatrist, is acting as consultant for the Covington Mental Health Clinic, it was announced. Doctor Bibb received his medical degree from Vanderbilt University in 1959 and interned at Vanderbilt Hospital. His residency was completed at Cincinnati General Hospital.

Dr. Izard to Direct Center

Robert M. Izard, Jr., M.D., Lexington, has been named medical director of the Rehabilitation Center in Louisville. Doctor Izard, who is currently serving as chief of physical medicine and rehabilitation at the Veterans Administration Hospital in Lexington, will take his Louisville post this summer. He is a graduate of Baylor University College of Medicine.

Public Health Assn. to Elect

A report of the newly elected officers of the Kentucky Public Health Association, which is holding its annual meeting as The Journal goes to press, will be carried in the June issue of The Journal. The meeting is being held in Louisville at the Kentucky Hotel.



Of 1,028 patients with confirmed respiratory infections... 954 or 92.8% were treated successfully with Signemycin®

Note:
Hammerl* selected his patients for treatment with Signemycin on the basis of demonstrated bacteriological resistance to other antibiotics or failure of previous therapy. Of 100 patients with various respiratory tract infections, 95 responded to Signemycin. Pathogens isolated included staphylococci and *Diplococcus pneumoniae*.

*Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958.

Condition	No. of Patients	No. Responded To Signemycin
Abscess, pulmonary	17	16
Bronchiectasis	19	13
Bronchitis	286	267
Bronchopneumonia	192	179
Empyema	12	11
Pneumonia, lobar	150	146
Pneumonia, other febrile	160	150
Various infected pneumopathies	192	172
Totals	1,028	954 (92.8%)

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Digest of Proceedings, KMA House of Delegates

March 17, 1965

A special meeting of the House of Delegates was held in Owensboro, Wednesday evening, March 17, 1965, to "consider pertinent items pertaining to current national health legislation."

The meeting, which was requested by the Board of Trustees, was called to order by Garnett Sweeney, M.D., speaker of the House. The following resolution was introduced by Robert E. Pennington, M.D., chairman of the KMA Board of Trustees:

WHEREAS, there has been introduced in the House of Representatives of the Eighty-Ninth U. S. Congress by Representative Cecil King H.R. 1 commonly referred to as medicare, which is a bill providing for limited health care for all citizens over age 65 regardless of need financed by an increase in social security taxes, and

WHEREAS, an identical bill, (S.B. 1) has been introduced in the U. S. Senate by Senator Clinton Anderson, and

WHEREAS, a bill, H.R. 3727, has been introduced in the U.S. House of Representatives by Representatives Herlong and Curtis which is also known as the Eldercare Act of 1965, which provides health care for persons age 65 and over who are in need determined by a simple income statement, which is administered by each state, and which utilizes private voluntary health insurance carriers, and

WHEREAS, the House of Delegates of the American Medical Association in special session in February voted to support the Herlong-Curtis Eldercare Bill and similar measures and voted to oppose H.R. 1 and S.B. 1 and all similar measures, and

WHEREAS, Kentucky citizens are growing more confused daily by the piece-meal reports on the kind of legislation the House Ways and Means Committee are putting together and these reports indicate that the committee is selecting parts of at least three measures introduced on this important issue and tying them together as one bill, and

WHEREAS, no public hearings have been scheduled by the House Ways and Means Committee on this complicated proposal so that no opportunity will be given to the people and to members of Congress to learn about all the provisions of this hybrid proposal including the total cost to the taxpayers, and

WHEREAS, the Herlong-Curtis Eldercare Bill, which the AMA supports, apparently will be given no public hearings at all under the present plans, and yet there is positive evidence that the Eldercare Bill—a practical, constructive, economical solution to the problem of helping the elderly who need help—has received tremendous popular support in all parts of the country, now therefore be it

RESOLVED that the House of Delegates of the Kentucky Medical Association support the Herlong-Curtis Eldercare Bill (H. R. 3727) and similar measures and oppose the King-Anderson Medicare Bill (H.R. 1 and S.B. 1) and similar measures, and be it further

RESOLVED that the members of the Kentucky Medical Association utilize every opportunity to inform their patients and their fellow citizens of the important characteristics of these measures, and be it further

RESOLVED that the Kentucky Medical Association appeal to the Representatives and Senators from Kentucky in the Eighty-Ninth U.S. Congress to use the full measure of their influence to insure that public hearings will be held on the respective merits of the "Medicare" and "Eldercare" Bills and to prevent the passage of a bill where haste is the major ingredient rather than reason or the public interest.

The House then voted to consider the resolution as if in a committee of the whole, and the following physicians spoke: Tim Lee Carter, M.D., congressman from the Fifth District of Kentucky; Durward Hall, M.D., congressman from the Seventh District of Missouri; Wesley W. Hall, M.D., Reno, Nevada, vice chairman of the AMA Board of Trustees, and Edward R. Annis, M.D., Miami, Florida, immediate past president of the AMA.

Following discussion, the question on the resolution was called for and the motion carried.

Thomson Bryant, M.D., president of the Fayette County Medical Society, who headed its delegation, presented the following resolution:

WHEREAS, Doctors of Medicine are dedicated to the eradication of heart disease, cancer and stroke, and

WHEREAS, the President's Commission on heart disease, cancer and stroke has recently submitted its report, and

WHEREAS, this report recommends the further intervention of the Federal Government in and the further alteration of current medical practice, and

WHEREAS, this intervention will significantly increase the tax burden of this country,

BE IT RESOLVED THAT:

1. The Fayette County Medical Society requests that the House of Delegates of the Kentucky Medical Association consider this report and that assistance be obtained from physicians, physician groups, legislators and other responsible citizens to inform the medical profession and the public, and
2. That the House of Delegates of the Kentucky Medical Association request that the Board of Trustees of the American Medical Association report their current activites concerning this proposal to the Kentucky Medical Association.

After discussion, the question was called for and the motion carried.

Before calling for a motion for adjournment, the Speaker expressed the appreciation of the members

(Continued on Page 374)



Of 425 patients with confirmed G.I. infections... 387 or 91.1% were treated successfully with Signemycin®

Note:
Loughlin and co-workers* achieved cure (absence of parasites) in all 100 of their patients with *chronic amebic colitis*. Feces became negative in all within the planned ten-day period of Signemycin administration. Upon re-examination of the feces six weeks later, the offending pathogen *(E. histolytica)* had reappeared in only 7 cases.

*Loughlin, E. H. et al.: Antibiot. Med. 7:739, Dec., 1960.

Condition	No. of Patients	No. Responded to Signemycin
Amebiasis	237	222
Cholecystitis and cholangitis	105	97
Enteritis	41	31
Peritonitis	15	14
Various, including pancreatitis, appendicitis and colitis	27	23
Totals	425	387 (91.1%)

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Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

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Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Responded To Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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of the House for the more than 250 people who attended the meeting and to Doctors Annis, Durward Hall, Wesley Hall and Carter for the contributions they had made.

Digest of Proceedings, KMA Board of Trustees

March 17, 1965

The meeting was called to order at 9:00 at Gabe's Motor Inn at Owensboro, following which the president acquainted the Board with the varied activities of his office.

The report of the AMA delegates on the recent special meeting of the AMA House of Delegates was given by J. Thomas Giannini, M.D., following which Henry B. Asman, M.D., secretary, submitted the report of the Headquarters office. The Board then named a committee to select the date and place for the 1966 Interim Meeting.

Dixie E. Snider, M.D., chairman of the Budget Committee, before presenting the proposed 1965-66 budget, explained that the Budget Committee had spent a full day in making the proposal and that the Executive Committee of the Board had on March 4 reviewed the budget and unanimously recommended it to the Board of Trustees. He pointed out that it was very much like the 1964-65 budget. After careful consideration and discussion, the Board approved the budget.

The Board then heard the recommendation from the specialty group presidents which was forwarded to it through the Council on Scientific Assembly and the Executive Committee that the honorarium for guest scientific speakers at our annual meeting be increased from $50 to $100. Motion to approve this recommendation was made and after discussion was adopted.

On the recommendation of the Council on Legislative Activities the Board approved a waiver prepared by the general counsel, Mr. E. Gaines Davis, Jr., for use by local grievance committees. The Headquarters office was authorized to send each county society information on this. John C. Quertermous, M.D., chairman of the Council on Legislative Activities for National Affairs, discussed the recent educational campaign.

The Board expressed official appreciation to Hoyt D. Garner, M.D. for his work in KEMPAC and to Arthur Keeney, M.D., who has chaired the Association's Committee on Highway Safety. Doctor Gardner was unable to serve longer on the KEMPAC Board because of a bylaw limitation and Doctor Keeney is concluding his service as a result of leaving the state.

The Board considered and approved a resolution for consideration by the House of Delegates at the special meeting scheduled for the evening of March 17 and disposed of other matters in this connection. Additions were made to certain committees as a result of resignations. Among other council recommendations were: approval of deactivating the postgraduate fund; decision to set up the fallout shelter in the KMA Headquarters Office not as a public shelter due to the smallness of its size; and the approving of a KMA certificate which might be presented by county societies to project winners at science fairs.

There was a lengthy discussion on the programs and activities of the Board of Health by Russell E. Teague, M.D., Commissioner of Health, and by members of the Board of Health. Robert F. Long, M.D., a representative of the Pulaski County Medical Society, reported on the adverse reaction of the members of his group to certain health department activities. Following discussion by members of the Board, a motion was passed referring the matter to a KMA committee to be named by the chairman for study.

Miscellaneous reports were heard and acted upon and there were several who made progress reports.

The Board, following a reading of a communication from the Kentucky Hospital Association on the matter of licensing foreign physicians, named a special committee to meet with representatives of the hospital association to study the problem.

The Board adjourned at 4:00 p.m.

The alcoholic *CAN* be rehabilitated

With a unique background of 80 years' experience, The Keeley Institute has earned an international reputation as a specialized hospital for the *restorative treatment* of the "problem drinker."

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one place your hay-fever patient doesn't need **ORNADE**® (unless he has a cold)

Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

...but if your patient can't get away from hay fever, relieve sneezing, weeping and nasal congestion for 24 hours with one 'Ornade' Spansule® brand sustained release capsule q12h

Summary of contraindications, cautions and side effects: Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction. Use with caution in the presence of hypertension, hyperthyroidism, or coronary artery disease. Drowsiness; excessive dryness of nose, throat or mouth; nervousness or insomnia may occur on rare occasions but are usually mild and transitory.

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Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

MAY

7, 14, 21, 28	Postgraduate Course in Pediatrics, U of L School of Medicine, Children's Hospital, 8:00 a.m. to 12:00 noon, EST, Louisville
12, 19	Fourth Semiannual Postgraduate Course in "Psychiatry in Practicing Physicians," U of L School of Medicine, course to be held at the Louisville Area Mental Health Center, 2:00-6:00 p.m., Louisville
13-14	Postgraduate Program on "Cardiac Emergencies," U of K Medical Center, registration begins 8:00 a.m., May 13, Lexington
20	University Surgery Day, 12:00 noon to 5:00 p.m., U of K Medical Center, Lexington
28	"Cardiology Night," 7:30 to 9:00 p.m., U of K Medical Center, Lexington

JUNE

10	KAGP Harrodsburg Seminar, Beaumont Inn, Harrodsburg
24	KAGP Henderson Seminar, First Christian Church, Henderson

JULY

21-22	KAGP Big Sandy Seminar, Jenny Wiley State Park, Prestonsburg

AUGUST

5	KAGP Bardstown Seminar, Bardstown High School, Bardstown
21-22	KAGP Bluegrass Seminar, Imperial House, Lexington

IN SURROUNDING STATES

MAY

14-16	Ohio State Radiological Society, Netherlands Plaza Hotel, Cincinnati
15-19	New Jersey Medical Society, Haddon Hall, Atlantic City
16-19	Illinois State Medical Society, Sherman House, Chicago
20-22	American Gynecological Society, Americana Hotel, New York
24-26	American College of Physicians, Postgraduate Course No. 15, Current Concepts in Gastroenterology, Royal Victoria Hospital, Montreal, Quebec
25-26	American Otological Society, Broadmoor Hotel, Colorado Springs
27-29	American Ophthalomological Society, Homestead Hotel, Hot Springs, Virginia
30-June 2	American Thoracic Society, Palmer House, Chicago

JUNE

7-11	American College of Physicians, Postgraduate Course No. 16, Basic Principles in Internal Medicine, State University of Iowa, Iowa City
8-12	American Association on Mental Deficiency, Americana Hotel, Miami Beach, Florida
9-11	American College of Physicians, Postgraduate Course No. 17, The Hemodynamic Basis for Auscultation, New York University Medical Center, New York
12-13	American Association of Neuropathologists, Hotel Dennis, Atlantic City, New Jersey
14-15	American Geriatrics Society, Inc., Roosevelt Hotel, New York
14-16	American Proctologic Society, Hotel Leamington, Minneapolis
14-16	American Neurological Association, Claridge Hotel, Atlantic City, New Jersey
14-18	American College of Physicians, Postgraduate Course No. 18, Psychiatry for the Internist, RESCHEDULED FOR NOVEMBER 1-5, University of Colorado Medical Center, Denver
14-18	American College of Physicians, Postgraduate Course No. 19, Hematology for Internists, in the Light of Recent Development, University of Rochester School of Medicine, Rochester, New York
15-19	American Medical Women's Association, Philadelphia
20-24	AMERICAN MEDICAL ASSOCIATION, Americana Hotel, New York

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Retardation Booklet Available

The recently published American Medical Association pamphlet and booklet "Mental Retardation —a Handbook for the Primary Physician" and "Who Helps the Physician Help the Retarded" will be available for reference use in your office and for general distribution. Logan Gragg, Jr., M.D., Lexington, chairman of the KMA Mental Health Committee, announced the booklet is a reprint of the article which appeared in the January 18, 1965 issue of JAMA.

The material is available to all physicians who request a single copy on their own letterhead. A nominal charge is to be made for additional copies. To order, write: Walter Wolman, Ph. D., Director, Department of Mental Health, American Medical Association, 535 North Dearborn St., Chicago, Ill., 60610.

Clinic Group Meets May 8

The American Association of Medical Clinics' Midwestern Regional meeting was held Saturday, May 8, at the Holiday Inn, Madisonville, hosted by the Trover Clinic, according to a recent announcement by Loman B. Trover, M.D., medical director of the Clinic.

Among the topics under discussion at the meeting were "Use of Surgery in Corrective Therapy", "Medical Care Programs in Kentucky", "AAMC in Washington", "Community Medicine", "Hospital Administration", and "Labor". Joseph B. Davis, M.D., Marion, Ind., president-elect of the AAMC, was a featured speaker.

Pertinent Paragraphs

Kentucky's Rural Medical Scholarship Loan Fund program is the topic of an article in the March/April issue of "PR Doctor", a guide to positive public relations published by the American Medical Association. The article describes the history, results, and operational methods of the program, which has received national praise from medical-education authorities.

The 19th Annual Rocky Mountain Cancer Conference, July 16-17, will be held at the Brown Palace Hotel. The two day session features some of the nation's distinguished speakers on the subject of cancer. The conference is co-sponsored by the Colorado Division of the American Cancer Society and the Colorado Medical Society. Further information may be obtained by writing Rocky Mountain Cancer Conference, 1809 E. 18th Ave., Denver, Colo., 80218.

"Clinical Cardiology" is the topic of the Cleveland Clinic Educational Foundation's postgraduate course to be held May 19 and 20 at the Clinic. For information, contact the Education Secretary, The Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland, O., 44106.



11:47 pm 11:53 pm 12:06 am

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KMA Council and Committee Reports

Mental Health Committee

Logan Gragg, Jr., M.D., Lexington, Chairman

KMA Headquarters Office **April 8, 1965**

At a recent meeting, the Committee on Mental Health reviewed the KMA Mental Health Congress held during May of 1964 and discussed future plans for the committee. Discussing the need for more interest of non-psychiatric physicians in the mental health field, the committee members felt the county medical societies could act as a stimulus in this area and recommended that a letter be sent to all county society secretaries urging them to appoint a mental health committee or a representative who could serve as liaison with the KMA Mental Health Committee.

It was taken by common consent that the availability of pamphlets from the National Committee on Children and Youth pertaining to mental retardation, and the AMA book entitled "Mental Retardation," be made known to the members of KMA through an article in the Journal.

Orientation Committee

N. Lewis Bosworth, M.D., Lexington, Chairman

KMA Headquarters Office **Thursday, April 1, 1965**

The KMA Orientation Committee met recently to plan KMA's first orientation course for new members. The committee members recommended to the Board of Trustees through the Council on Communications and Public Service an agenda which included the speakers to be invited and subjects selected for the first orientation course, which will be held Monday, September 21, just prior to the 1965 KMA Annual Meeting.

Members of the committee noted that according to KMA Bylaws, a new member is in a provisional status until he completes the orientation course, which he must do during his first two years of membership. The recommendation was made that "Provisional Status" be typed on members' cards for those members in this category. The Committee members felt Section 5. Chapter 1 of the KMA Bylaws which pertains to membership and which was revised by the 1964 KMA House of Delegates, might be of interest to county medical societies when county society bylaws are revised.

Diabetes Committee

Irving F. Kanner, M.D., Lexington, Chairman

KMA Headquarters Office **March 31, 1965**

Members of the Diabetes Committee met at the KMA Headquarters to review previous Diabetes Programs, and after considerable discussion the committee made plans for its 1965 Drive this fall, which will be held November 14-20.

The chairman announced that a total of 103,248 tests were reported as a result of the 1964 Drive and expressed a desire to see this record broken in 1965. The committee members reviewed the method of reporting and urged county chairmen to submit their final reports to the KMA Headquarters Office as promptly as possible. The committee also received a report of the proposed Louisville Memorial Hospital Diabetes Detection Program from Carlisle Morse, M.D., Louisville, State American Diabetes Association Coordinator.

Public Health Committee

Ralph D. Lynn, M.D., Elkton, Chairman

KMA Headquarters Office **March 11, 1965**

The Public Health Committee met at the KMA Headquarters Office March 11 and approved a promotional program for Immunization Week which the members set for May 2-8. It was pointed out that Kentucky's compulsory immunization law requires that all parents, guardians, and other persons having care, custody, or control of any child under 18 years of age, shall have the child immunized against diphtheria, tetanus, poliomyelitis, and pertussis within twelve months after birth. Committee members also noted that since this law was passed, research has come up with a safer vaccine for the prevention of measles.

Committee members also agreed that a letter should be sent to all county medical society secretaries depicting the acute need for better reporting of syphilis to the responsible VD investigators. A recommendation was approved and sent to the Board of Trustees through the Council on Communications and Public Service urging that all county medical societies join with local groups in the eradication of rabies, to get dogs vaccinated and licensed, and to get a good dog-control program started.

The State Commissioner of Public Health was guest of the committee and reported on various health programs in his department.

Physical Medicine and Rehabilitation Committee

William K. Massie, Jr., M.D., Lexington, Chairman

KMA Headquarters Office **March 25, 1965**

The KMA Committee on Physical Medicine and Rehabilitation held its first meeting of the Associational year and reviewed its duties and various assignments members had been given to research as a result of the committee's report to the 1964 House of Delegates. Committee members discussed primarily the necessity of taking an active interest in rehabilitation, retraining, re-employment, and relocation in order to fulfill duties of the committee.

It was pointed out that members were meeting with other groups, state officials, and professions, who are interested in rehabilitation and who want to solve many problems which the members feel exist in this area.

The committee will meet again on June 3 in the KMA Headquarters Office to prepare its final report to the 1965 session of the House of Delegates.

McDowell Home Committee

Laman A. Gray, M.D., Louisville, Chairman

KMA Headquarters Office **Saturday, March 20, 1965**

The McDowell Home Committee, meeting for the second time this year, discussed numerous items pertaining to maintenance and publicity of the Home. Members of the Committee expressed their desire to see more Kentucky physicians visit the McDowell Home.

The chairman announced at the meeting that the McDowell Home was being designated a registered national historic landmark by the United States Department of Interior and would be presented with a plaque and a certificate. The committee members expressed their desire for an appropriate ceremony for this presentation in the early fall. The committee will meet again in late April or early May.

The Physician and the Press

(Continued from Page 351)

back with this note: "Pete . . . this sounds like it could be interesting, but we don't know what it means. If you have it rewritten so the average man of the street understands it, or it relates to the everyday life of the house wife and other readers, we may be able to use it."

Dale Carnegie wrote in his book, *Public Speaking:* "I remember hearing a physician say in a talk that 'diaphragmatic breathing is a distinct aid to peristaltic action of the intestines, and a boon to health.' "

Carnegie stopped the speaker and asked the layman audience for a show of hands from those who understood what the physician had said. None did.

I told some physicians this story. "But that's the only way to say it," one insisted.

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This insistence on technical jargon is one of our big problems with professional people.

Lawyers have a saying: "A man who acts as his own counsel in court has a fool for a lawyer."

This might be paraphrased: "A physician who handles his own news releases has a quack for a public relations man."

I don't mean this in most cases, but do stress emphatically the importance of getting help and advice . . . of talking things over with your publisher, editor or reporter, and with people from other media. They can and almost always will help if approached properly, as happened at Spartanburg.

Try to understand the problems of newspapers and other media. Try to help.

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*Swartz, C., et al.: Circulation 28:1042, 1963.

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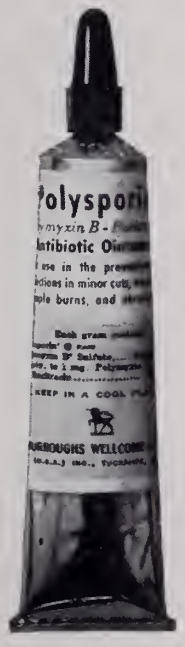
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COUNTY SOCIETY REPORTS

Bell

Frank T. Smith, M.D., Middlesboro, was chosen to head the Bell County Medical Society, it was announced. Adam Stacy, M.D., Pineville, was named vice-president, and Robert B. Cloar, M.D., Middlesboro, as secretary-treasurer. C. B. Stacy, M.D., Pineville, and M. J. Evans, M.D., Middlesboro, will be delegates to KMA. Alternates have not yet been elected.

Bourbon

James L. Ferrell, M.D., Paris, was elected 1965 president of the Bourbon County Medical Society. Isadore Zapolsky, M.D., Paris, will serve as vice-president, and James E. Johnson, Jr., M.D., Millersburg, as secretary-treasurer. Doctor Ferrell will serve as delegate to KMA and Doctor Zapolsky as alternate.

Breathitt

Robert E. Cornett, M.D., is president of the Breathitt County Medical Society for 1965, it has been reported. Also elected were Price Sewell, Jr., M.D., president-elect; and F. C. Lewis, M.D., secretary. Doctor Lewis will serve as delegate to KMA and Doctor Cornett as alternate delegate. All are from Jackson.

Breckinridge

James G. Sills, M.D., Hardinsburg, was elected president of the Breckinridge County Medical Society for 1965. Harold Owens, M.D., Irvington, was chosen vice-president; and William J. Cates, M.D., Cloverport, will serve as secretary-treasurer. Doctor Sills is delegate to KMA and Doctor Cates is the alternate delegate.

Calloway

Conrad H. Jones, M.D., Murray, will head the Calloway County Medical Society for the coming year, it was recently announced. Other officers, also from Murray, are: Harry U. Whayne, M.D., vice-president; J. R. Ammons, M.D., secretary-treasurer; C. C. Lowry, M.D., KMA delegate; and Hugh L. Houston, M.D., alternate.

Carroll

New president of the Carroll County Medical Society is E. S. Weaver, M.D., Carrollton. James D. Ford, M.D., Carrollton, is secretary-treasurer. Doctor Weaver will serve as KMA delegate.

Estill

Omar C. Amstutz, M.D., Irvine, took office April 1 as president of the Estill County Medical Society. Assisting Doctor Amstutz in his duties will be Virginia Wallace, M.D., Irvine, secretary; Raymond Snowden, M.D., Ravenna, delegate to KMA, and S. G. Marcum, M.D., Irvine, alternate.

Floyd

Lowell Martin, M.D., Martin, has been named president of the Floyd County Medical Society for 1965. Other officers chosen were: J. A. Holbrook, M.D., Prestonsburg, vice-president; and Russell L. Hall, M.D., Prestonsburg, secretary-treasurer and KMA delegate. Doctor Martin will serve as alternate KMA delegate.

Franklin

The president of the Franklin County Medical Society for the coming year will be Sanford L. Weiler, M.D., it was reported. Also elected were: John P. Stewart, M.D., vice-president; and Carl E. Shroat, M.D., secretary-treasurer. Doctor Stewart and Harry J. Cowherd, M.D., will serve as delegates to KMA, with James T. Ramsey, M.D. and Edward K. Martin, M.D., as alternates. All the officers are from Frankfort.

Fulton

David L. Jones, M.D., will serve as president to the Fulton County Medical Society for 1965. Doctor Jones is from Fulton, as are the following newly elected officers: R. R. Rudd, M.D., vice-president; J. A. Poe, M.D., secretary-treasurer; R. Ward Bushart, M.D., KMA delegate; and Glynn F. Bushart, M.D., alternate.

Graves

John M. Reed, M.D., Mayfield, has been elected president of the Graves County Medical Society, and Larry L. Hall, M.D., secretary-treasurer. Doctor Reed will be the County's delegate to KMA, and Robert A. Orr, M.D., will serve as alternate. Doctors Hall and Orr are also from Mayfield.

Greenup

C. B. Johnson, M.D., was named president of the Greenup County Medical Society, it was recently announced. Other officers serving with Doctor Johnson will be: Virgil Skaggs, M.D., vice-president; J. G. Boggs, M.D., president-elect; and C. I. Haeberle, M.D., secretary-treasurer. Ted J. Sanders, M.D., will be the County Society's delegate to KMA, and John O. Jones, M.D., alternate delegate. With the exception of Doctors Sanders and Jones, who are from Flatwoods, all the officers are from Russell.

Hart

The 1965 president of the Hart County Medical Society, who took office in March, is Robert Upton, M.D., Munfordville. Vice-president this year is G. P. Peterson, M.D., Horse Cave, and secretary-treasurer is James E. McAfee, M.D., Horse Cave. A delegate and alternate were not reported.

Hopkins

W. R. Jernigan, M.D., was elected president of the Hopkins County Medical Society for the coming year. Also elected were: W. A. Kirchner, M.D., vice-president; K. P. Haywood, M.D., secretary-treasurer; L. C. Trover, M.D., Madisonville, and F. A. Scott, M. D., KMA delegates; and T. S. Smith, M.D., and F. F. Furguson, M.D., alternate delegates. All are from Madisonville.

Jessamine

The Jessamine County Medical Society this year

elected Marvin C. Pentz, M.D., Nicholasville, as its president for a two-year term of office. Also elected were V. C. Gillispie, M.D., Wilmore, vice-president; J. S. Williams, M.D., Nicholasville, secretary-treasurer and delegate to KMA; and Dale E. Dunkelberger, M.D., Wilmore, alternate delegate.

Madison

R. Eugene Bowling, M.D., Richmond, will serve as president of the Madison County Medical Society for the coming year, it was recently reported. Doctor Bowling will be assisted by the following officers: Clifford E. Kerby, M.D., Berea, vice-president; William D. Epling, M.D., Berea, secretary-treasurer; Douglas Jenkins, M.D., Richmond, and Dwight L. Blackburn, M.D., Berea, delegates to KMA. William G. Clouse, M.D., Richmond, and Doctor Bowling will serve as alternate delegates.

McLean

Everett Coleman, M.D., Sacramento, was chosen to head the McLean County Medical Society for the coming year, it was reported. Other officers for 1965 are: Samuel Scott, M.D., Livermore, vice-president; and W. Gerald Edds, M.D., Calhoun, secretary-treasurer and alternate KMA delegate. Doctor Coleman will serve as KMA delegate.

Morgan

George Bellamy, M.D., was elected president of the Morgan County Medical Society for the coming year. Also serving as officers will be: Morris L. Peyton, M.D., vice-president and president-elect; and Alec Spencer, M.D., secretary-treasurer. Doctor Peyton will be the County's delegate to KMA and Doctor Bellamy the alternate delegate. All are from West Liberty.

Nicholas

J. T. Morford, M.D., Carlisle, will serve as president of the Nicholas County Medical Society for the associational year, it was announced. Wendell R. Kingsolver, M.D., Carlisle, will serve as secretary. Doctor Kingsolver is delegate to KMA and Doctor Morford, alternate.

Powell

J. F. Knox, M.D., Stanton, is president and C. G. Noss is secretary-treasurer of the Powell County Medical Society, it was reported recently. Doctor Noss will serve as delegate to KMA and Doctor Knox as alternate. Both are from Stanton.

Rowan

Everett D. Blair, M.D., Morehead, has been elected president of the Rowan County Medical Society for 1965. Assisting him will be George C. Barber, M.D., Morehead, vice-president; and F. Calvin Bigler, M.D., Morehead, secretary-treasurer. A KMA delegate and alternate have not yet been named.

Russell

The Russell County Medical Society elected as its president for the coming year James B. Tarter, M.D., Russell Springs. Charles E. Peck, M.D., Russell Springs, will serve as secretary and David L. Lawrence, M.D., Jamestown, as delegate to KMA. Doctor Peck will be alternate delegate.

Scott

Fred W. Wilt, M.D., was elected to head the Scott County Medical Society for the coming associational year, it has been reported. Also elected was J. C. Cantrill, M.D., secretary-treasurer and KMA delegate. Doctor Wilt will serve as alternate delegate. Both are from Georgetown.

Trigg

The new president of the Trigg County Medical Society is Thornton Bryan, Jr., M.D. John Futrell, M.D., was named vice-president, and Elias N. Futrell, M.D., secretary-treasurer. Doctor Bryan will serve as KMA delegate and Doctor Elias Futrell as alternate.

Wayne

Claude L. McHargue, M.D., Monticello, took office April 1 as 1965 president of the Wayne County Medical Society, it was recently reported. Other officers named were: Robert B. Breeding, M.D., vice-president; William R. Kelsay, Jr., M.D., secretary-treasurer; and John W. Simmons, M.D., KMA delegate. Doctor Breeding will serve as alternate. All are from Monticello.

In Memoriam

BRENT WEDDLE, M.D.
Somerset, Ky.
1884 - 1965

Brent Weddle, M.D., 80, who was named Outstanding General Practitioner of 1958 by the Kentucky Medical Association, died March 27 at St. Petersburg, Fla., where he had lived since his retirement. A graduate of the Medical Department of the University of Louisville in 1908, Doctor Weddle had practiced in Pulaski County since that time.

RELDA EARL ELLIOTT, M.D.
Marion, Ky.
1893 - 1965

R. E. Elliott, M.D., who had practiced in Crittenden County since 1952 and in Lexington for 25 years before that, died suddenly at his home at Marion at the age of 72. Doctor Elliott, who practiced general medicine and surgery, received his M.D. degree from the University of Louisville School of Medicine in 1920. He was a native of Amory, Miss.

JAMES ARTHUR STUMBO, M.D.
Martin, Ky.
1905 - 1965

James A. Stumbo, M.D., 59, Floyd County general practitioner and surgeon for 25 years, died March 3

(Continued on Page 390)

to help relieve pain in common anorectal disorders

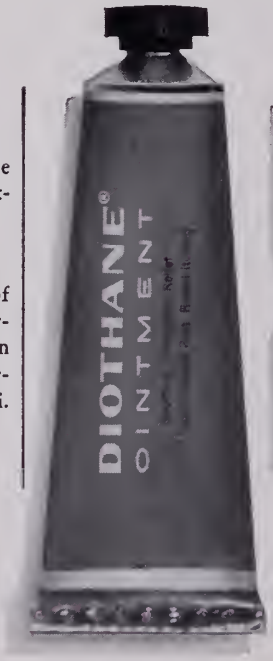
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at Lexington following a short illness. Doctor Stumbo, a native of Salisbury in Floyd County, was a 1935 graduate of the Medical College of South Carolina and had practiced in West Virginia before moving to Martin.

SAMUEL MEDFORD BOWMAN, M.D.
Summer Shade, Ky.
1882 - 1965

S. M. Bowman, M.D., 82, retired Metcalfe County general practitioner, died March 19 at the home of his son at Glasgow. A native of Monroe County, Doctor Bowman graduated in 1909 from the Medical Department of the University of Louisville. He had retired from practice in 1963.

WILLIAM COWAN GOSE, M.D.
Pikeville, Ky.
1907 - 1965

W. C. Gose, M.D., Pikeville general practitioner since 1935, died suddenly at his home on March 17 following an apparent heart attack. Doctor Gose received his medical degree from the University of Louisville School of Medicine in 1932.

GERALD BERNARD SCHROERER, M.D.
Hopkinsville, Ky.
1925 - 1965

Gerald B. Schroerer, M.D., 40, a member of the staff of Western State Hospital, Hopkinsville, who formerly practiced in Louisville and Sturgis, was killed April 10 in an automobile accident in Union County. Doctor Schroering, a graduate of the University School of Medicine in 1949, recently moved to Hopkinsville from Sturgis.

Sigmoidal Diverticulitis
(Continued from Page 340)

cal procedures that are available and that I believe are compulsory for the more complicated aspects of diverticulitis. A number of disappointments have occurred for the surgeon and those patients who have had a one-stage resection and have developed postoperative complications, particularly fistula formation. I believe that the one-stage resection should be restricted to patients who have a small area of diverticulitis without much obstruction or penetration, without *any* perforation or abscess formation, and with no diverticula elsewhere in the colon.

Case Discussion—Head Trauma
(Continued from Page 349)

together with atrophy of the normal fat pad of the orbit. With this atrophy of the fat pad, the enophthalmos which is present is extremely hard to correct.

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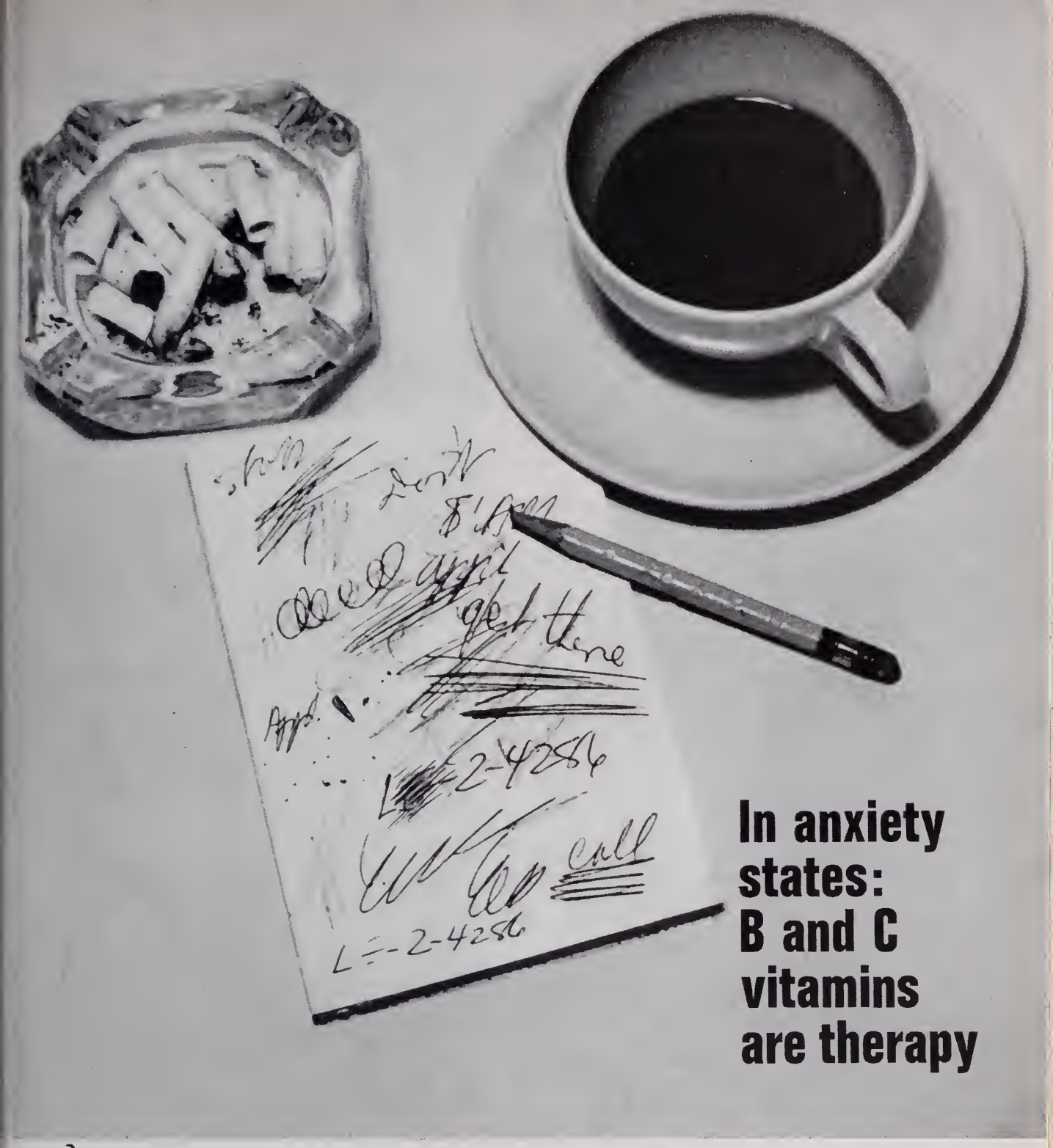
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Routinism, Iatrogenetics

(Continued from Page 337)

general surgeon concluded, as a result of seeing patients with hemorrhage in the brain and retroperitoneal areas, etc., that no patient should be carried on anticoagulants unless hospitalized.

Summary

Thus in conclusion iatrogenics has to do with both the good and bad influence of the physician on the course of the patient's illness.

The "good" of the physician-patient relationship has always been with us, and will continue, being the art that makes the science most effective. On the other hand the complexities of modern care have given the physician a greater potential to create iatrogenic disorders. While some of these must be accepted in order to achieve certain diagnostic and therapeutic triumphs, others cannot be accepted because they are preventable. Routinism aids and abets these preventable physician-produced sicknesses since it denies the basic concept of the variability of each patient and his individual reaction to prescriptions, procedures and surgical ministrations.

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"The Cumberlands—Mountains of Trouble" is the title of an article appearing in the March-April issue of the SK&F Psychiatric Reporter. The article deals with the activities of the Pikeville (Ky.) Mental Health Clinic, which provides aftercare for patients discharged from Eastern State Hospital in Lexington. Reprints may be obtained by writing to Robert L. Dean, Editor, SK&F Psychiatric Reporter, Smith Kline and French Laboratories, 1500 Spring Garden St., Philadelphia, Pa., 19101.



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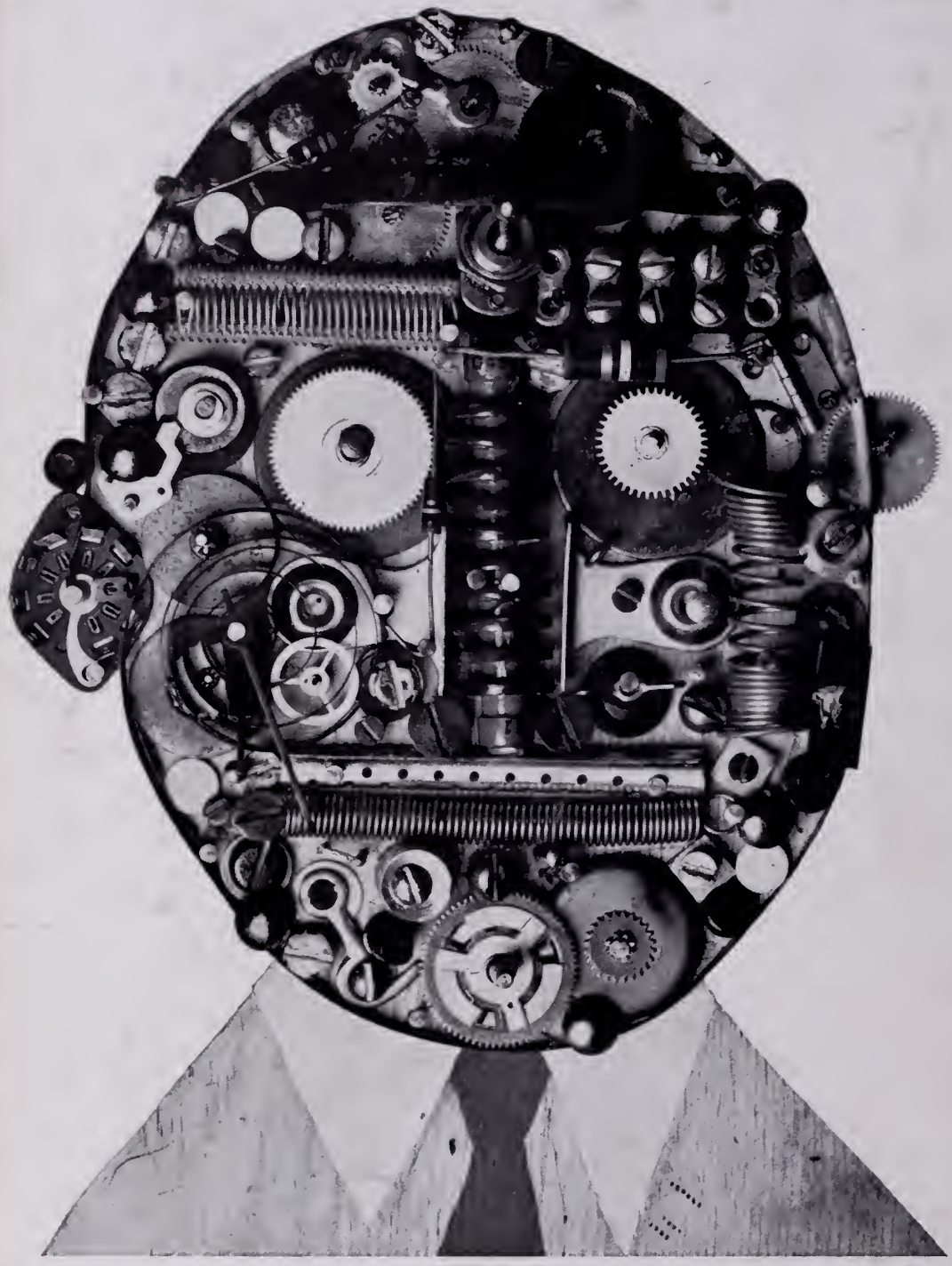
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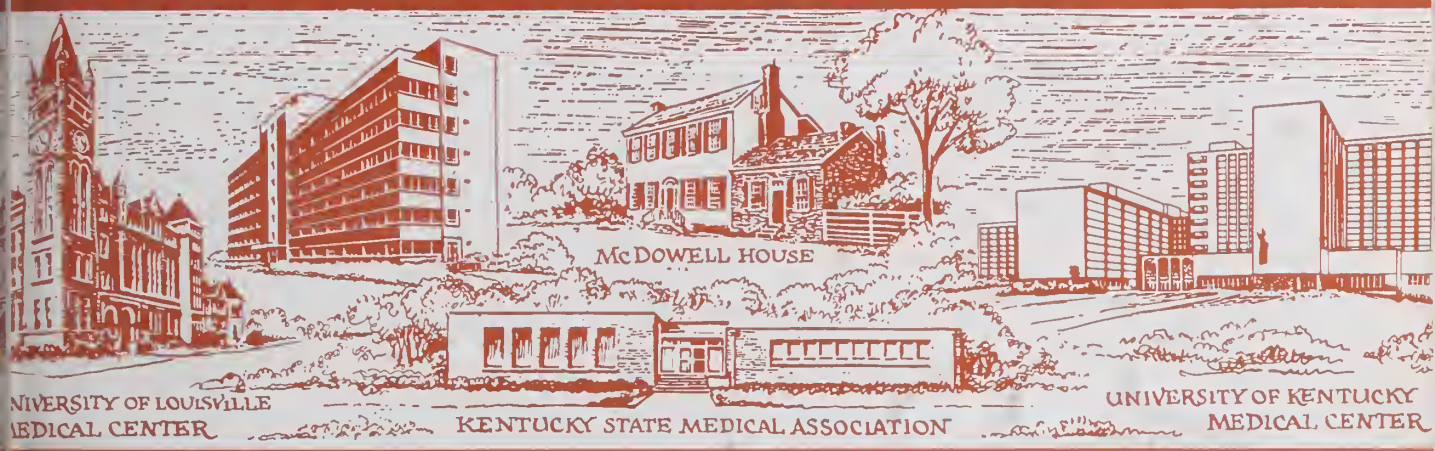
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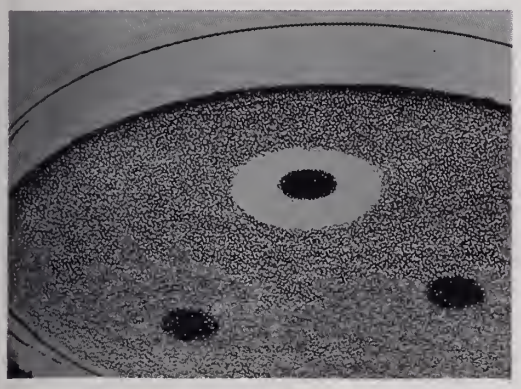
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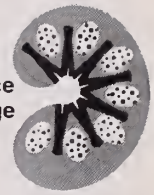
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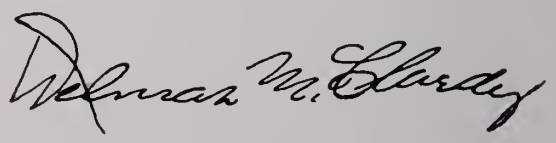
A Foot in the Door

An editorial entitled "Eldercare Has a Tonic Effect on Medicare," appeared in a leading national newspaper on March 25. It stated, "The new bill is a revolutionary step forward for the United States, but it is still far from the government-financed medical care that nearly all other civilized countries take for granted. A speedy passage through the House and Senate would help the President keep one of the major pledges of his Great Society, and it would also help bring us part way into the 20th century."

The lawmakers and the social planners have been denying that "King-Anderson" is socialized medicine or would lead to it. The above is the first bold admission of what is in store and this should be a stimulus for renewed effort to resist the determination to reduce the world's finest medical care to something less. Extreme methods have been used against the people in this attempt. No doubt, extreme methods will have to be used if the same high degree of medical care is maintained.

The President does not practice medicine, neither does Congress. A socialized system of medical care can be imposed upon the public only by physicians who choose to impose it, through their willingness to cooperate in the destruction of their own profession, which means destruction of first class medical care.

The often-heard phrase, "If you can't whip 'em, join 'em," is a sorry attitude, a sign of weakness and an invitation to destruction. Nothing superior has ever been gained, or maintained, by capitulation.



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THE INSURANCE PAGE



Prevailing Fees

THE major portion of all pre-paid medical insurance in this country is purchased through employee benefit plans. Representatives of management and labor who negotiate the purchase of these medical benefits have consistently expressed a strong preference for programs that provide benefits for covered services on a "paid-in-full" basis.

The demands for such programs by the major employers in the automobile, steel, and rubber industries has already led commercial insurers to underwrite programs providing the payment of "usual and customary" fees to physicians. These payments are made without reference to fee schedules, and without requiring participating physicians to make any commitment with reference to their charge to the carrier or patient for services performed.

These programs, while appearing to overcome various objections, inherent in existing service and indemnity programs, present problems in control and administration which many major purchasers believe to be too unpredictable and without controls adequate to insure the financial stability of the program.

Some Blue Shield service programs have attempted to provide benefits on a "paid-in-full" basis to subscribers when their incomes are within limits established by the plan and its sponsoring medical society. These programs have not, however, provided the full "predictability" that plan payments would cover all costs in their entirety. Thus, major group purchasers offer resistance to such programs because they lack full assurance of comprehensive coverage.

It has become evident that Blue Shield *must* devise a method of providing coverage that will assure members that the cost of health care they receive *will* be met by their insurance. In an effort to devise such a program, the National Association of Blue Shield Plans has devoted considerable study to the development of the "Prevailing Fee" plan.

In this program, actual charges by physicians are determined by a survey of doctors or by reference to data available in Blue Shield or Medical Society records. This information is used to establish a range of "Prevailing Fees" representing the charges made by up to 90% of the doctors in a given geographic area. Thus, plan payments for medical services would relate consistently to other economic characteristics of the area in which they are made.

Under this program, there would be, in effect, a profile of fees charged by each physician, and each physician would bill the plan just as he would bill an individual patient. Blue Shield would pay each doctor the amount he billed. Maximum payment for a given service would be within the range of fees charged by 90% of the practicing physicians in an area. Payment to those doctors whose fees exceed the charges of nine out of ten of the physicians in the area would be indemnity payments, but would still bear some relationship to the prevailing fees being paid in the area.

The "Prevailing Fee" approach, while providing benefits on a "paid-in-full" basis, is not based on fixed fee schedules which a physician is required to accept regardless of their applicability to his practice of charging patients. Instead, the actual charges of physicians in an area serve as the determinant of the charges each doctor makes and the payment he receives. Thus, the physicians themselves establish their own charges, which are in turn used to establish levels of payment.

The small number of physicians whose charges exceed those of 90% of their colleagues is minimal when considered in relation to the capability of the program in providing paid-in-full benefits on a basis that appears to be acceptable to physicians, subscribers and major employers.

The Jefferson County Medical Society recently gave approval to the "Prevailing Fees" program in their area. Clearly, no single dramatic solution will be found for the many problems of providing pre-paid comprehensive coverage, but this approach appears to be a step in the right direction.

WILLIAM W. HALL, M.D.

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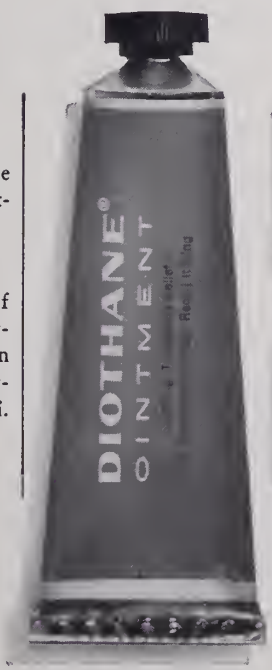
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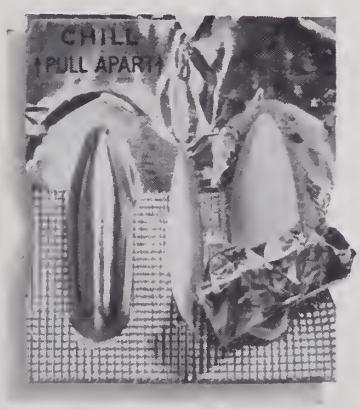
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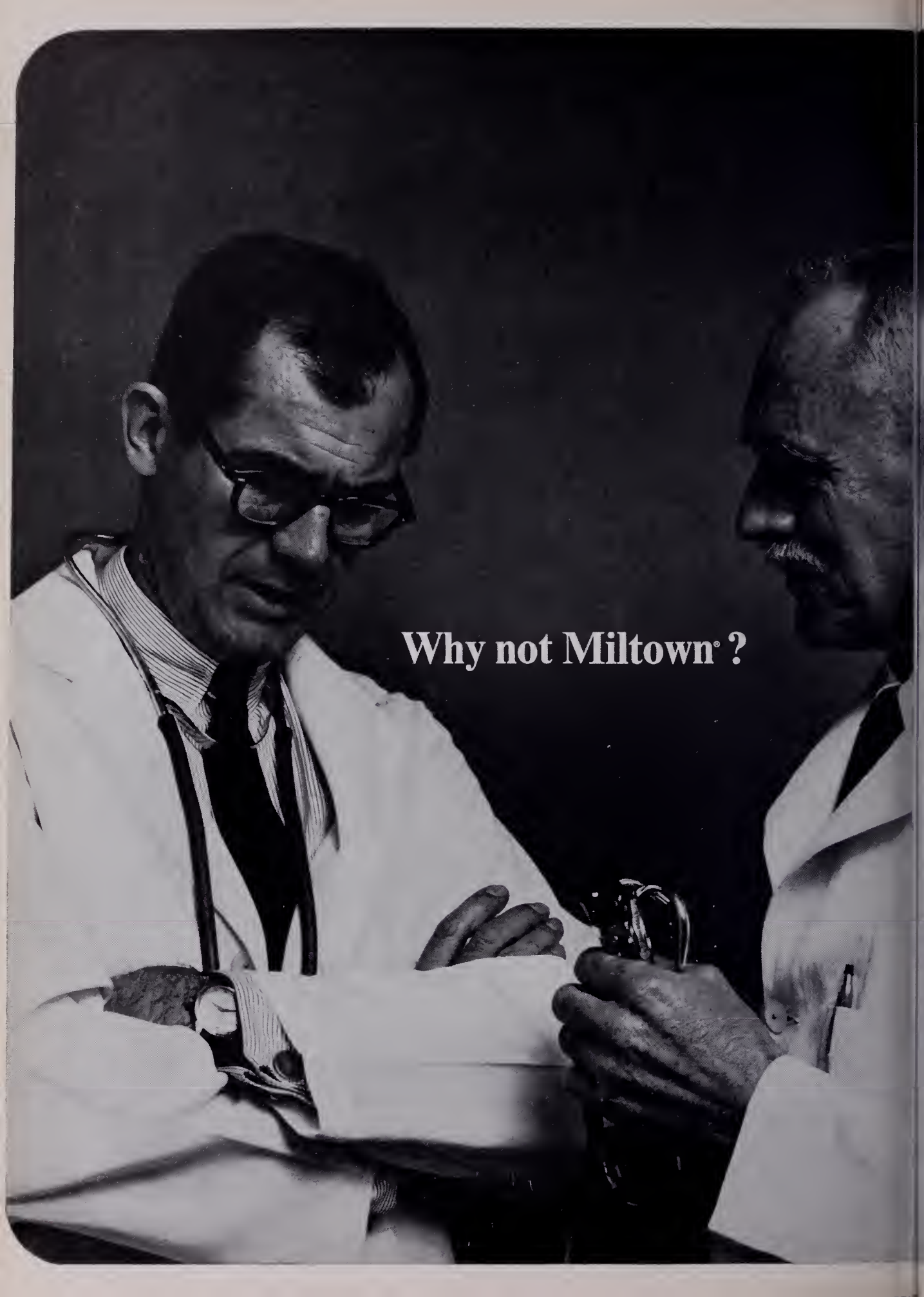
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FUNDAMENTALS OF ORTHOPAEDICS: by John J. Gartland, M.D.; Published by W. B. Saunders Company, Philadelphia, 1965; 338 Pages; Price, $8.00.

In his introduction Gartland described this as "a basic and introductory book intended principally to acquaint the student with the specialty and indicate to him the scope . . ." This he has accomplished in a very readable manner.

The field of orthopaedics is covered well but briefly. He has approached his subject in a logical arrangement starting with the basic review followed by principles, congenital deformities, disorder of the epiphysis, etc., ending with bone tumors. There is a section treating the extremities and back in individual chapters.

Frequently there are cross-references to other portions of the book. There is a two-page Glossary of orthopaedic terminology at the end and good bibliography for each chapter.

For the purpose the book is intended, as an introductory book to students and general information to practitioners, to this end the book does its job well and can be recommended.

FRED E. COY, JR. M.D.

THE LIVER AND PORTAL HYPERTENSION: by Charles G. Child, III, M.D.; Vol. I in the series Major Problems in Clinical Surgery. Published by W. B. Saunders Company, Philadelphia, 1964; 231 Pages; Price, $8.50.

This attractive, well illustrated little book with its tremendous bibliography is an up-to-date reference book for the practicing surgeon, resident and teacher. It is a symposium by one of the most distinguished liver teams in the country. The seven chapters, each with its separate authors, give both the historical high points as well as the latest developments in the study of this complex field. Thus Chapter VI includes the new and interesting studies in the increased lymph flow and pressure within the thoracic duct system accompanying both portal hypertension and cardiac decompensation. Chapter VII summarizes and illustrates the experimental surgery thus far done upon the portal vessels.

The reading is not easy any more than is the subject matter, but the reader is stimulated to explore in addition the numerous references for greater clarification. The pages on medical treatment, while describing standard measures, emphasizes the underlying physiological principles and promising new therapies based upon them.

Chapter I on the surgery of portal hypertension is complete and authoritative. Doctor Child's figures and analyses clarify such problems as the prognosis of surgical versus purely medical therapy; the operative risk in the good and fair surgical candidate in contrast to the poor candidate; and the long term outlook offered by the various types of shunt. Careful detail is given on all aspects of therapy, as, for instance, how long to leave the Blakemore tube inflated and in the shunt operation the vital importance of visualizing and meticulously ligating all of the delicate branches on the left side of the portal vein as opposed to blind digital dissection.

JOSEPH E. HAMILTON, M.D.

EXPERIENCE IN RENAL TRANSPLANTATION: by Thomas E. Starzl, Ph.D., M.D.,; Published by W.B. Saunders Company, Philadelphia, 1964. 383 Pages; Price, $17.00

This book will undoubtedly be required reading for anyone interested in organ transplantation, particularly renal transplantation. This careful and accurate appraisal of the clinical experience of one of the pioneer groups in the field is filled with photomicrographs, charts, and illustrations that supplement the well-written text. The earlier portions are devoted to the selection and preparation of donors and recipients, the technique of the operation itself, and details of the postoperative care of these difficult problems. Quite properly, a great deal of emphasis is placed upon the early diagnosis and vigorous treatment of threatened graft rejection.

One of the most valuable sections of the book is devoted to an analysis of the causes of failure. The late complications that led to these failures are carefuly reviewed along with the accompanying immunological and pathological changes. As a result, the outstanding feature of the book is that the knowledge gleaned from the tragedies can be, and in fact has been, applied to prevention of their recurrence.

The book is the result of a six-month hiatus in the activities of the Denver group, this time being spent to assess and record these results. This in itself is an unusual and highly commendable approach to an experimental clinical procedure in these days when the emphasis is on being first with the largest series. The book ends on a note of cautious optimism that would appear to be warranted on the basis of results published.

ALLAN M. LANSING, M.D.

NOTE—CORRECTION: *In the May issue of The Journal, a review of the book "Clinical Neurology", was incorrectly attributed to Ephraim Roseman, M.D. The review was written by Armin F. Haerer, M.D., instead. The Journal regrets this error and apologizes to both Doctors Haerer and Roseman.*











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*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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Treatment of Metastatic Lesions to the Lung†

Alton Ochsner, M.D.*
New Orleans, La.

Based on personal experience as well as that of others, resection of metastatic disease of the lung in indicated cases is worthwhile. Among 25 patients the survival rate after one year was 57 per cent, after five years, 27 per cent, and after ten years, 20 per cent.

TREATMENT of cancer is now on a firm scientific basis. As attested by the experience of the American Cancer Society, more than a million patients with malignant disease have been completely cured. If the primary tumor can be detected and either completely excised or destroyed before it has extended to other parts of the body, a cure can be obtained. In many instances, however, either because of the early invasive properties of the neoplasm or because of delay in institution of adequate therapy, the disease has extended not only to the regional lymph nodes but also to distant foci. Even in patients with involvement of regional lymph nodes cure can sometimes be obtained by *en bloc* excision of the primary tumor and involved regional lymph nodes. The worst prognosis, of course, is in those patients whose disease has invaded the bloodstream with development of distant metastases. Next to the viscera drained by the portal system, the lung is the organ most frequently involved with metastasis. The reason for this is that the first capillary bed encountered after leaving a viscus, in the case of angio-invasive malignant disease, is the pulmonary capillary system. As a matter of fact, in the follow-up treatment of all patients with malignant disease roentgenograms of the chest are taken repeatedly to determine whether there is evidence of pulmonary metastasis.

Generally, if distant metastases have occurred, the condition is considered hopeless. Occasionally, however, if the distant metastasis is to the lung only, and other definite criteria are fulfilled, surgical excision of the pulmonary metastasis is justifiable. Whereas the pulmonary metastasis may be the only metastatic lesion, it must be presumed that there are others. For this reason, a pulmonary metastatic tumor should not be surgically excised without telling the patient and his family that there may be metastatic foci other than the pulmonary lesion. If, however, no other metastasis can be detected and the primary neoplasm has apparently been adequately removed, one can reasonably assume that it is the only metastatic lesion and therefore should be removed. Another possibility is that the lesion in the lung is another primary carcinoma or an inflammatory condition unrelated to the original neoplasm. Since the disease within the lung may not be the only metastatic lesion, it should not be removed unless there is a good chance of the patient surviving the operation. Moreover, as little pulmonary tissue as possible should be excised. Wedge resection, segmental resection, or

† *Presented at the September 30 General Session of the 1964 Kentucky Medical Association Annual Meeting in Louisville, September 29-October 1, 1964.*

* *Director of surgery, Ochsner Clinic and Ochsner Foundation Hospital, New Orleans, and emeritus professor of surgery at Tulane University School of Medicine.*

lobectomy is to be preferred to pneumonectomy. Pneumonectomy is justified only if it is impossible to remove the metastatic lesion otherwise.

A Survey of Reports

Divis[1] performed the first successful resection of pulmonary metastasis in 1926 in Germany. Four years later Torek[2] performed the first successful resection of metastatic disease of the lung in the United States although the lesion was considered preoperatively to be a primary one. Barney and Churchill[3] were the first in the United States to remove what was considered to be a metastatic lesion, when they removed a metastatic adenocarcinoma of the kidney which had extended to the lung. In their case the disease in the lung was detected first but there was also evidence of a renal tumor. Nephrectomy was done on April 18, 1932, and a diagnosis of adenocarcinoma was made. The pulmonary tumor, which was thought to be metastatic, was treated first unsuccessfully by irradiation, and on July 18, 1933, wedge resection of the upper lobe of the left lung was done; the tumor was found to be metastatic. This patient died of coronary disease twenty-three years later.[4] We[5] have estimated that probably more than 500 similar cases have been encountered. In 1961 Moersch and Clagett[6] stated that more than 400 cases had been recorded. They reported the largest series on record (169 operations on 165 patients); 73 of their patients had been operated on more than five years previously. There were 86 females and 75 males, ranging in age from 4 to 75 years with an average age of 54 years.

Richardson[7] collected 35 cases of pulmonary metastasis in children treated by excision, of whom 63 per cent were alive. Of the 35, 17 had been treated for Wilm's tumor, 14 of whom were among the survivors. Thirteen of the 17 with Wilm's tumors were apparently well two years after resection and five after five years.

White and Krivit[8] reported two cases of long-term survival after resection of pulmonary metastasis. One was a 21 month-old baby treated by nephrectomy and irradiation (Wilm's tumor) in whom one year later two nodules developed in the left upper lobe, which were removed by wedge resection; the patient was well ten years later. The second was a six year-old child with a rhabdomyosarcoma in the right side of the neck, which was incompletely excised and treated with 3000 roentgens. Nine months later a nodule developed in the lingula and was removed by wedge resection; the child was well five years later.

Wilkins and associates[4] reported that during a period of twenty-eight years, 67 patients had undergone 75 operations for removal of pulmonary metastasis at the Massachusetts General Hospital. One patient had three separate thoractomies, four had bilateral operations, and in two second procedures were done on the same side. Of these 67, the primary site was colon and rectum in 17, kidney in 16, connective tissue in seven, uterus in five, bladder in four, bone in four, testis in three, and miscellaneous in seven; four had melanomas. They noted that carcinomas arising in the kidney, large intestine, and uterus had the best prognosis and that in general the presence of positive nodes in the specimen of the primary lesion was a bad prognostic sign.

Points in Prognosis

Their study indicated that limited resection of the lung is desirable. None of their 12 patients requiring pneumonectomy survived five years and only two survived two years. The five-year survival rate for those who had lobectomy was 22 per cent; segmental resection, 25 per cent; and local removal, 17 per cent.

Wilkins and associates also observed, as have others[6,] that the longer the interval between removal of the primary tumor and development of pulmonary metastasis the better the prognosis. Of 40 patients in whom pulmonary metastatic disease had been removed less than five years after the primary operation, only four survived five years after the second operation. Of 20 in whom the second operation had been done more than five years after the primary operation, eight survived an additional five years. Of seven patients in whom the metastatic lesion was removed before the primary tumor was known, only one was alive. Moersch and Clagett[6] reported a three-year survival rate of 13.6 per cent in patients in whom this interval was less than one year; 40.7 per cent when the interval was one to four years, and 44.4 per cent for an interval of more than five years, or an average three-year survival rate of 35.4 per cent. Although Strieder's[9] statistics do not substantiate his contention that there is little relationship between the survival rate and the in-

terval between removal of the original tumor and the metastatic lesion, of his ten patients who were living, four or more years had elapsed between appearance of the tumor and the original operation, whereas of the ten who had died, in only three did the tumor appear this late.

Our experience suggests that the prognosis is influenced by the length of the interval before the appearance of the pulmonary metastasis. Although our series is small, of the 16 patients who are dead the median interval between primary resection and pulmonary resection was thirty-nine months, whereas it was fifty months in the nine living patients. This is particularly significant because the patient with the longest interval (three hundred months) is dead.

Alexander and Haight[10] found the prognosis to be better in patients with sarcoma. Of their 24 patients, 16 had carcinoma and 8 sarcoma. Six of the eight with sarcoma but only six of the 16 with carcinoma were living. Kelly and Lanston[11] also reported better results in sarcoma than in carcinoma. Of their 38 patients with sarcoma 11 survived more than two years, and of the 65 with carcinoma only eight survived that long. Moersch and Clagett, on the other hand, reported a higher survival rate for carcinoma than sarcoma, the respective seven-year survival rates being 25.6 and 16.7 per cent. Strieder[9] reported similar results, their statistics being 41 per cent for carcinoma and only 38 per cent for sarcoma. Among 355 cases collected by Wilkins and associates[4] of 254 with carcinoma only 18 survived five years as compared with 16 of 101 with sarcoma.

Ochsner Clinic Experience

At the Ochsner Clinic we have had 25 patients with pulmonary metastasis on whom 28 operations were done, three having had two operations. Fourteen had carcinomas and eleven sarcomas. Of the 14 with carcinoma, four had adenocarcinoma of the breast, three adenocarcinoma of the rectum and colon, three metastatic melanomas, two lesions originating in the testes (one seminoma and one embryonal adenocarcinoma), one undifferentiated carcinoma of the stomach, and one squamous cell carcinoma of the cervix. Of the eleven sarcomas, eight were soft part sarcomas and three, osteogenic sarcomas; two of the eight soft part sarcomas were crystosarcoma phylloides, two were fibrosarcomas, and one each, malignant mesenchynoma, liposarcoma, rhabdomyosarcoma, and angiosarcoma.

Among the twenty-eight operations, eleven were lobectomies, five pneumonectomies, five multiple resections (lobectomy, multiple segmental resection, or lobectomy and segmental resection), four segmental or wedge resections, and three composite resections (removal of the thoracic wall, bony thorax, and pulmonary tissue). There were no operative or hospital deaths in this series. Ten patients died within the first year. One, known to be alive at the end of three months, was lost to follow-up, three died at three months, one at four, one at six, two at seven, and one each at eight, nine and ten months. Three patients, operated on less than a year previously, are living, two of whom have no evidence of recurrence. Of the twelve living at the end of one year, four died within three years (at thirteen, fifteen, eighteen, and thirty months), one is living and apparently well (two years), and one is living with recurrent disease (thirteen months). Two died between the third and fifth years (at forty-seven and fifty-five months), two are living between five and ten years (eighty-two and one hundred months), and two are living more than ten years (one hundred thirty-four and one hundred sixty-seven months).

The best results were obtained in the two patients with testicular tumors, both of whom are living more than ten years after operation. The poorest results were in patients with osseous malignant lesions. All three patients (two with osteogenic sarcoma and one with fibrosarcoma) died within three years. All except one of eight patients with soft part sarcomas are dead (at four, seven, eight, nine, thirteen, eighteen, and fifty-five months). One patient, a young man with an angiosarcoma of the thigh, is well one hundred and four months after pulmonary resection of the metastatic tumor. Of the three patients with malignant melanoma, two died at three and seven months, respectively, and one is apparently free of disease three months after the pulmonary operation. One patient with squamous cell carcinoma of the cervix died three months after pulmonary resection. Another patient with undifferentiated carcinoma of the stomach died at fifteen months. The shortest period of survival in the entire group was three months; the longest one hundred and ninety-one months.

Summary

In conclusion, it bears repeating that a metastatic lesion of the lung must be removed only after careful deliberation because of the possibility of existence of other undetected metastatic lesions. On the other hand, if the primary lesion is the only metastatic tumor, its removal offers the only hope for cure. Performance of this procedure is justified, provided the patient and his family understand that it may be done unnecessarily if other metastatic tumors are present. Because it may be done unnecessarily, one must be sure that it can be done with little or no risk unless the patient is suffering from symptoms as the result of the metastasis, such as suppuration or hemorrhage. Our results confirm those of others that the procedure is worthwhile if the conditions outlined are satisfied. We have had no operative deaths. Among 25 patients, the survival rate after a year was 57 per cent, after five years, 27 per cent, and after ten years, 20 per cent. Although these statistics leave much to be desired, they appear good when one recalls that without the operation the survival rate at the end of two, and certainly five and ten years, would probably be zero. In view of the fact that these survival rates represent total salvage, resection of metastatic disease of the lung in indicated cases is worthwhile.

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A Case of Sporotrichosis Cleared When Given Griseofulvin

Ullin W. Leavell, Jr., M.D.*
Lexington, Ky.

There have been very few cases reported of sporotrichosis treated with griseofulvin. There is a good deal of question in the cases reported as to the effectiveness of the drug in this disorder. A case is reported which responded to griseofulvin.

SPOROTRICHOSIS is a fungus disease caused by Sporotrichum schenkii. It gains entry to the body through minor injuries such as occur on the hands and feet and is most frequently seen in farmers and florists but has been described also in horses, mules, dogs, cats and rats.[1] The fungus has been isolated from grass used in packing pottery[2] contaminated sawdust,[3] flowers, grains, bark, thorns, vegetables, fleas, ants,[4] sphagnum moss[5] and salt hay mulch.[6]

The most common form of the disease is the localized lymphatic form. In this type the fungus gains entry to the body secondary to a minor injury of the skin. In about 3 to 4 weeks a chancrelike lesion appears. It is ulcerated centrally and has an elevated periphery which is firm and hard. In a few weeks multiple subcutaneous nodules may appear along the course of the lymphatics.[7] These lesions are fluctuant and on incision exude pus. The fungus grows well on Sabouraud's media and may be isolated from the chancre as well as from the subcutaneous nodules.

Systemic involvement may occur. The fungus has been found in the lung,[8,9] meninges,[10] eyes,[11] bones, glands, joints, mouth, muscles, and pharynx.[4] Fatalities occasionally occur from the disorder. The disease may persist for months or years if untreated. There is little tendency to spontaneous involution.

Microscopy shows a granuloma containing histiocytes, epitheloid cells, giant cells, lymphocytes, and occasional polymorphonuclear leukocytes. Organisms have been seen in the skin, bone marrow, spleen,[12] lungs, sputum, and knee.[13]

The immunity developed by sporotrichosis results in a high resistance which accounts for localized clinical forms, occasional spontaneous cures, and the curative results of iodine therapy. There is a much higher percentage of positive intradermal tests with Sporotrichum in people working in dermatology clinics than in endemic areas.[14]

Potassium iodide is specific in its cure of sporotrichosis. It has been used for years and its therapeutic effect is well documented. It is inexpensive to give over long periods of time. However, there are some individuals who do not tolerate the medication either in its liquid form or the enteric-coated tablets. For this reason it is well to find other methods of therapy for this disorder. The literature is divided at this time as to the effectiveness of griseofulvin.

Case History

A six-year-old white female, first seen on November 25, 1961, presented with a growth, of about four months duration, on the right side of her chin. The lesion started as a round purple elevated area with a small blister in the center. The area had broken down and had been draining. There was no history of injury to the area.

Self-treatment had included an ointment which the patient's father had used for eczema, "intestinal flu" medicine, blood tonics, vitamins with iron, cod liver oil tablets, a white ointment, a pink liquid, a small capsule, a cream-colored ointment, and a white cream. Since the onset of the present difficulty, the patient had complained of stomach trouble. She denied the ingestion of drugs for her bowels and for headaches.

There was an ulcerated lesion 3.0 cm. in

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FIGURE 1.



FIGURE 2.

diameter on the right side of the chin (Fig. 1). The border was elevated. There was an erythematous fluctuant sinus extending from the ulcer onto the neck. The sinus measured 1.0 by 4.0 cm.

The impression was that the lesion was a granuloma, probably blastomycosis.

Complete blood studies and urinalysis were within normal limits. A chest x-ray showed no active lesion. Tuberculin and histoplasmin intradermal tests were negative.

A biopsy showed marked infiltration of lymphocytes, neutrophils, and plasma cells.

In the cutis, there were nests of epitheloid cells and occasional multinucleated giant cells of the Langhans type. There was a superficial exudate of serum and neutrophils. The acid-fast stain was negative. PAS stains showed branching structures resembling mycelia in one or two foci.

Cultures of pus from the lesion on Sabouraud's agar grew a black growth which was identified as Sporotrichum schenkii.

The patient was given griseofulvin 250 mg. four times daily, for three months. There was marked improvement in two weeks and in six weeks the lesion had healed over. The medication was continued for an additional six weeks. She tolerated the griseofulvin well. The lesion on the chin showed progressive improvement and she was discharged on April 6, 1962 (Fig. 2).

Discussion

Latapi[15] reported cures of four cases of sporotrichosis after 250 mg. of griseofulvin twice daily for four weeks. At the time of the report there were an additional four cases which were improved but had not been followed for a sufficient length of time.

Robinson and Roberts[16] have reported a case of sporotrichosis that failed to respond to griseofulvin over a four-week period. Wrong[17] reported a case that failed to respond to griseofulvin over a four-week period. Latapi[18] reported a clinical cure in four weeks in one patient given griseofulvin 250 mg. twice daily. Lyons[19] reported a case of sporotrichosis that cleared in eight weeks on 500 mg. of griseofulvin twice daily. Watt[20] reported progression of the disease while one patient was on griseofulvin therapy.

Roth[21] points out that Sporotrichum schenkii was completely insensitive to griseofulvin in concentrations up to 25 mg. per ml. Emmons et al[22] reported that sporotrichum is insensitive to potassium iodide media containing 10 per cent potassium iodide. The treatment with these two agents is empirical and based solely on clinical grounds. It may be that griseofulvin causes the fungus to fail to reproduce in the tissues. It may be that there is an increase in the immunity of the host. An adequate dosage is necessary and one should be sure that the patient is taking the medication. The treatment should be continued for three or four weeks afer the case has been cured. Positive cultures have been reported for as long as one month after treatment.

	Cured	Improved	Failure
Latapi	4	4	
Robinson			1
Wrong			1
Latapi	1		
Lyons	1		
Watt			1
Total	6	4	3

Too few cases of sporotrichosis treated with griseofulvin have been reported to form a definite opinion regarding the effectiveness of this preparation. It is hoped that more cases will be reported in the future so this issue may be further clarified.

(Continued on Page 456)

Experiences in Primary Closure of the Common Bile Duct Following Its Exploration

Royce E. Dawson, M.D.

Owensboro, Ky.

This is a study of common bile duct explorations, comparing T-tube drainage and primary closure of the duct. The study points out that primary closure is practical and safe when applied properly.

EXPLORATION of the common bile duct has always been considered a major surgical procedure. The addition of T-tube drainage with associated increased morbidity, hospital stay, and inconvenience adds more to the procedure. The common bile duct can be closed primarily with safety if certain conditions are met.

Primary closure of the common bile duct following its exploration without T-tube or catheter drainage is not a new concept in surgery of the biliary tract. The procedure is used in several areas in the United States and papers on the subject have appeared in French, German, and South American literature.

The interest in and use of this concept in the Department of Surgery at Vanderbilt University School of Medicine stimulated the author to use it in private practice and to review those cases[2].

This case study represents all cases of biliary tract surgery, with the exception of carcinoma, done by the partnership of Doctors Dodson, Davis and Dawson during the period of January 1, 1956 through December 31, 1961. During the early part of this study, the procedure of choice was T-tube drainage of the common duct; whereas, during the latter part of the study, the procedure of choice was primary closure of the duct.

The common indications for exploration of the common bile duct were used; i.e., history of jaundice, small stones in the gall bladder, history of pancreatitis, palpable stone in the common duct, enlarged common duct, and a large cystic duct. T-tube drainage was ordinarily used in cases with a small common duct, stricture of the common duct, pus in the common duct or marked peri-ductal inflammation, and in some few cases when sphincterotomy was done. A T-tube was also used when the common duct was perforated during exploration or this was suspected.

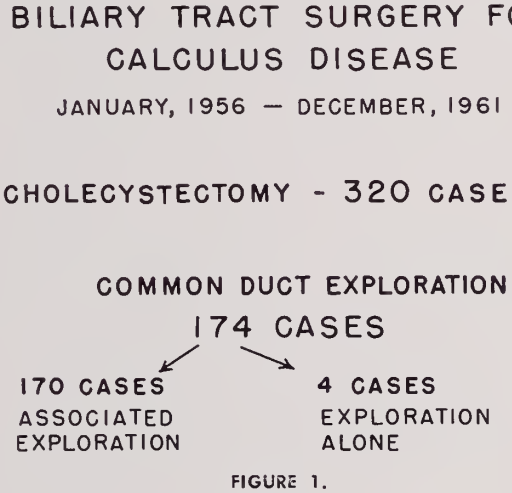


FIGURE 1.

In all cases of exploration of the duct, it was opened longitudinally between stay sutures and explored with stone forceps. Following this, the sphincter of Oddi was dilated with Bake's dilators to at least 6 mm and larger if possible. The duct was then irrigated thoroughly in both directions and closed longitudinally with a continuous 4-0 chromic catgut gastro-intestinal suture. When a T-tube was used, the duct was closed around it in a similar manner. Operative cholangiography was not used. A soft rubber drain was used in all cases, being placed in or near the foramen of Winslow and being brought out through a stab wound.

Report of Cases

A total of 324 cases of biliary tract surgery, excluding carcinoma, were reviewed as shown in Figure 1. There was a total of 320 cholecystectomies and four cases in which the gall bladder had been removed previously. 170 cases had exploration of the common duct at the

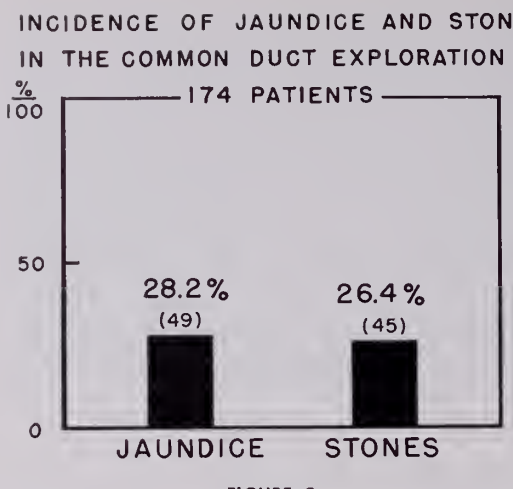


FIGURE 2.

time of cholecystectomy, giving a total of 174 patients with exploration of the common bile duct.

It is interesting to note that the average age of the patients having exploration of the common duct was 49.8. The youngest patient was 16 years of age and the oldest 82 years of age. Forty-nine patients in the group were either jaundiced at the time of surgery or had a history of jaundice, and this represents 28.2% of the total. Forty-five patients, 26.4%, had stones in the common bile duct (Fig. 2). Stones were found in the common duct in 24 (48.9%) of those patients with a history of jaundice. In the remaining 125 cases there was no history of jaundice and stones were found in the common duct in 21 (16.8%) of these patients. Thus the incidence of stones found at surgery was 16.8% in those patients without a history of jaundice but with other indications for exploring the common duct and 48.9% in

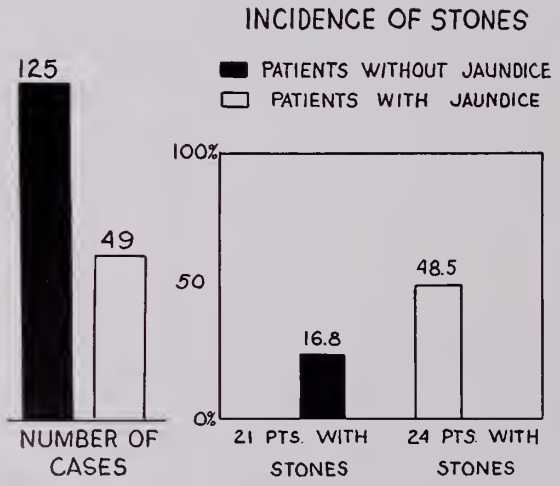


FIGURE 3.

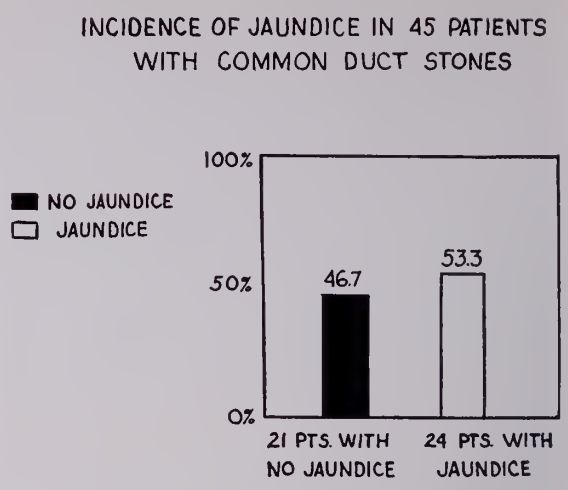


FIGURE 4.

those patients with a history of jaundice (Fig. 3). It is also interesting to note that there was no history of jaundice in 21 (47.6%) patients with stones found in the common duct at the time of surgery while 24 (53.3%) had history of jaundice. (Fig. 4).

Of the 174 cases of exploration of the common bile duct, 109 (62.6%) had the common duct closed primarily and 65 (37.4%) had T-tube drainage. The average age of the patients undergoing common duct closure was 48.4 years and of those having T-tube drainage was 50.6 years.

The average length of hospital stay was 10.4 days in the group having their duct closed primarily, while it was 12.4 days in the group undergoing T-tube drainage. The average number of days the temperature was over 100 is less significant. In the group in which the common duct was closed primarily this was 2.9

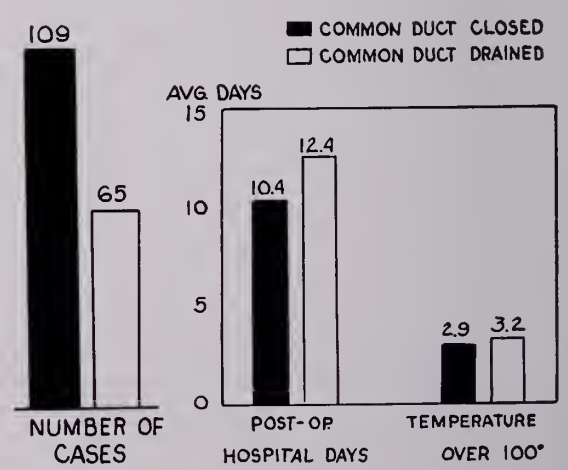


FIGURE 5.

— Common Duct Closure —

Post Operative Complications (No Deaths)

3 Wound Disruption
1 Pneumonia
1 Adrenal Failure
1 Pancreatitis
1 Post Operative Jaundice that Subsided

7

FIGURE 6

— Common Duct Drainage —

Post Operative Complications and Deaths

Expired	Recovered
1 Duodenal Fistula	1 Post-Op. Jaundice that Cleared
1 Cerebrovascular Accident	1 Wound Disruption
1 Congestive Failure	1 Prolonged Bile Drainage
1 Pancreatitis	
4	3

FIGURE 7

days, and in the group that had T-tube drainage it was 3.2 days. (Fig. 5).

The mortality rate was lower in the group with primary closure of the common duct, with no deaths. There were four deaths in the group undergoing T-tube drainage. These deaths were due to subphrenic abscess with duodenal fistula, cerebral embolus, intractable congestive failure and pancreatitis. Major complications in both groups are seen in Figures 6 and 7.

Discussion

We feel that closure of the common duct following its exploration has several advantages. In this series of cases, along with other series, it has been shown that the post operative morbidity is less, and the length of hospital stay is shortened. There does not appear to be a great deal of difference in the number of related biliary tract complications. It is felt that one of the most important things in primary closure of the common bile duct is to complete a thorough exploration of both the hepatic and common ducts and to dilate the sphincter of Oddi to a suitable size, usually 6-7 millimeters, with Bake's dilators. A meticulous closure of the common duct is necessary. The importance of dilatation of the sphincter of Oddi is well shown in a paper by Allen and Wallace[1] in 1940 in which they showed that secondary operations were necessary in 4.2% of 214 patients who had no dilatation after common duct exploration and .7% of 561 patients who had dilatation. All surgeons occasionally leave small stones or fragments of stones, and many of these will pass if the sphincter of Oddi is dilated.

Summary

A six year experience in the surgical treatment of the common bile duct for calculi is presented. The hospital stay in shortened, there is lower post operative morbidity, and there is less inconvenience to the patient when the common bile duct is sutured primarily without T-tube drainage. At the present time, primary closure of the common bile duct is the procedure of choice.

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The Physician's Contribution to Emotional Wellness†

Trawick H. Stubbs, M.D.*

Atlanta, Ga.

The physician's opportunity goes beyond his vitally important role in healing the sick. Essential to an emotionally healthy society are the avoidance of inappropriate dependency and the increase in creative capacities of responsible individuals.

OUR local medical society has a committee working on how best to use for the public good some forty-five thousand dollars which is the balance from contributions in the recent SOS polio vaccination campaign in our county. This endeavor was a significant demonstration of one way in which people can protect their own health other than through the use of tax funds and government agency action. The combined efforts of private business (drug manufacturer), organized medicine, volunteer services of physicians, nurses, pharmacists, and other professionals, and the support of citizens (represented by the volunteer workers and by the contributions of persons receiving the vaccine), demonstrate some important principles. Some of the same principles involved in this example of communicable disease control are potentially involved in whatever future methods are developed for assuring public mental health.

To me, the phrase, "mental health," is not an adequate term. I do not know an adequate one, but I am using in this discussion the phrase, "emotional wellness." Perhaps we can think together for these few minutes about the emotional wellness of your patients—sick persons and their families who depend on you for help. We might also give equal attention to the emotional well-being of the total population. I would urge each of you to direct your own creative considerations to the role of the physician, both as an individual and through organized medicine, and of the opportunities that exist for assuring a high level of emotional well-being for the citizens of Kentucky (and similarly of other states in our country.) Also, all of us are citizens as well as physicians, and have a responsible stake in non-professional activities —both as individuals and as members of organized groups.

I've always liked the classification of life experience into 1) filling things that are empty, 2) emptying things that are full, and 3) scratching where it itches. Just as arbitrarily, I'll divide my remarks into 1) what the physician does himself, 2) what he does together with others, and 3) what he sees to it that someone else does.

What You Do Yourself

As director of a hospital, I was confronted some years ago with rather severe criticism of the hospital and the orthopedic service because a college girl had been treated for a broken leg, and according to the complaint, no one had known that she broke it in an attempted suicide jump from a window when she found she was pregnant. It reminded me of a patient I had as an intern, who had torn off half his little finger in a similar jump; no one in the hospital dealt with his major problem of not wanting to live. It is easy to exhort every physician to treat the total person. There is seldom time to do all we would like to do. Each practitioner has to establish his own realistic limits and balances, as one method of protecting his own emotional health.

A survey of Georgia physicians two years ago revealed a broad range of individual attitudes. I listened to some 70 taped interviews made by a medical student employed for this project, and was reminded again that it is a good thing for different doctors to see things differently. Some openly declared a policy of spending no time at all discussing emotional

† *Presented at the September 29 General Session of the 1964 KMA Annual Meeting in Louisville.*

* *Director of the Community Mental Health Service of the Georgia Department of Public Health, Atlanta.*

problems; others would like to if they had time; others made it a point to. Some never referred a patient to a psychiatrist; some not only referred frequently, but sought consultation on many cases, without referring. There is, no doubt, the same range of appropriate differences among Kentucky physicians. I am not here to propose that you accept any one point of view but rather to encourage you in the good you are doing.

The medical profession as a whole is being confronted as never before with the joint responsibility for meeting more of the demand for services to the mentally ill. The so-called mental health field now claims alcoholism, mental retardation, delinquency, and various other conditions of troubled or troublesome persons and families. I am convinced that medicine as a whole will have to help psychiatry define what part of its function is truly "medical." It may be easier sometime for the general physician than for the psychiatrist to suggest where further responsibility for help should be. When should the individual be urged or forced to handle his own problem? When is what appears to be a health problem really a problem of learning or a social or moral or economic problem? How often is it a situation where there is no right answer to the question of which helping profession is the proper one, but clearly a matter where any one of a number of different persons could help with equal effectiveness, given the time and the concern for and respect for the person? How often are you now carrying some of the sickest emotional cases, because there is no one else to do it?

I have spent considerable time discussing with psychiatrist friends the matter of the need for continuing psychiatric education for physicians. One thing seems clear to me. If there is some thing that non-psychiatrist physicians could do better in relation to emotional aspects of illness, it is very likely that many of the better physicians are already doing it. It seems to me important to recognize that there is a *mutual* opportunity for learning and growing, as psychiatrists and other physicians work together. Few psychiatrists have much experience with the anxiety of the dying patient or the common family grief situations. An internist remarked to me a few weeks ago that he had never seen a psychiatrist who really knew first hand about the emotional turmoil in families faced with a terminal, progressive chronic disease. Excellence in professional practice is developed by those who have first-hand experience. The physician, being on the ground, is now carrying the major load as the available professional helping person in many emotional crises. He is reinforced by many other helping persons and professionals, including the psychiatrist. In considering practically what physicians can do better, or do more of, it is first important to recognize what is already being done. Many of you are involved daily in helping patients and families through stress situations, which, without your help, would be overwhelming.

What You Do Together

Many of you remember the "pest house" for small pox and other diseases. We have not yet outgrown the era of "pest houses" in the hospitalization of the mentally ill. However, promising progress is being made along this line in the changing image of the mental hospital. The current emphasis on the role of the community general hospital as a front line resource in services to persons incapacitated by mental illness is encouraging. Georgia has operated for about seven years a program of purchasing services for medically indigent patients from the psychiatric department of five general hospitals throughout the state. It is now our policy to enter into an arrangement with a hospital only after the proposed program plan has been reviewed by an appropriate committee which can speak for the entire medical staff of the hospital. The basis for this policy is the realization that the overall responsibility for guiding development of services to the mentally ill is a responsibility shared by all of medicine, not just by the clinical specialty of psychiatry. You are aware of the activities of the Council on Mental Health of the American Medical Association, and undoubtedly many of you attended the state conference last May which was held here in Kentucky.

The shared responsibility in working together goes beyond the medical staff and the hospital staff and includes numerous other community agencies. But the team approach may reach a point of diminishing returns. Several years ago at an interagency conference about the Community Hospital Psychiatric Program (formerly Intensive Treatment Program) a note of caution was sounded in regard to multiple-agency involvement. When a number of

people are eager to help a family, each naturally wants to be most helpful. It is sometimes easy to take over as agent for the family and forget to put responsibility where it belongs. Thus, we witness the paradox of the cooperating helping persons inadvertently increasing the dependency of the patient and family, when inappropriate dependency was a major element in the family emotional illness to begin with.

However, it is obvious that effective service calls for combined efforts in many forms, over and beyond what families can do for themselves. Appropriate combinations of public and private resources are essential. I am thankful that in our society now (and I hope it will be true for all time) there is not, and cannot be, any single authority under which public and private programs can be directed to coordinate their programs. Since combined efforts must be on a voluntary, mutually acceptable basis, perhaps words like "harmonize" and "orchestrate" are better than "integrate" and "coordinate". It is clear that for the foreseeable future private medicine will provide the backbone of services to the sick. It disturbs me to realize that some of us who work for the people on public programs are sometimes perceived as enemies of private practice. It should be obvious to all that the best way for individuals and families to carry their own responsibility is to arrange for their private care. The important point is this. In doing things together, there are many ways of combining effectively public and private resources without killing the individual incentive, which is after all the only source of group strength. Particularly in the provision of services to the mentally ill we are facing a new day. The inevitable increase in local responsibility for higher quality service involves increased involvement and responsibility for private medicine—and for all physicians, not just the psychiatrists. In the evolution of mental health services, we face one of the most challenging opportunities for better balances among individual and professional responsibility and private and public service programs.

One example from Georgia which calls for more effective team work is the acute need for more adequate after-care. Despite the statewide program of public health nursing service to state hospital patients, there is very little medical or psychiatric supervision for indigent patients close to home. We continue to work at formulating policies for assisting local hospitals to furnish more outpatient service, including drugs. Our position for years has been that we cannot consider any state program for furnishing drugs until there is adequate medical supervision. This does not necessarily require a psychiatrist. Progress calls for combining psychiatric and general medical service as well as combining public and private resources, and combining state and local financing. This job will not be done without the active involvement of physicians throughout the state.

The cooperative effort so urgently needed is by no means limited to services to those who are already sick. I mentioned inappropriate dependency. I know of no more important challenge than to identify and describe more clearly the points in our culture where we tolerate inappropriate dependency; and then find ways to avoid all forms of inappropriate dependency. Admittedly it is difficult to define what is inappropriate.

The traditional authority-dependency relationship between physician and patient has been sometimes an all-or-none proposition, especially in the hospital. When my wife's mother several years ago went to the hospital with a broken hip, it took her three days to get permission to use her regular eye drops. On the other side, this morning on the *Today* show on T.V., some of the tuberculosis patients at the Will Rogers Memorial Hospital were interviewed. One was smoking. When asked about it, she said, "The doctor advises against it, of course, but he recognizes us as adults and puts the responsibility on us." Once in a group discussion we were looking together at some of our cultural stereotypes of using illness as an excuse for avoiding responsibility. One member finally convinced us he was quite serious in presenting the view that if a child soiled the rug by vomiting, he should be punished just as he might be for tracking mud on the rug. This is the point. The physician is surrounded with strong influences in the form of cultural expectations about illness—both professional and lay—which may pose many dilemmas. It is not easy to know in any particular instance what balance in the authority-dependency relation will be most conducive to emotional health for all concerned. It may be even more difficult to achieve the balance which is desirable.

One thing we need to do together is to find ways of increasing individual and family re-

sponsibility for our own emotional well-being. The efforts of individual physicians and of organized medicine aimed at increasing individual responsibility are an important part of the effort to attain a higher level of emotional wellness in our total population. And this is just as important many times as treating the sick.

What You Get Others To Do

As physicians we function individually—providing clinical service; we function as members of groups—treatment teams, hospital staffs, medical societies. We are also persons and citizens, again functioning both as individuals and in groups—families, civic groups, churches, and a variety of organizations. As persons and citizens, as well as in our professional roles, we share responsibility for seeing that things are done in our communities which we do not do ourselves, either separately or with others.

The physician's voice is heard and respected as communities try to organize their resources to meet their needs. As a public mental health agency, for example, the state health department in Georgia should be able to help local communities set priorities for using their limited resources. County Commissioners may ask, "In developing services that will assure a high level of emotional wellness for the people in our county, what is most important? Should we first develop general hospital psychiatric services when we don't have a psychiatrist? Should we employ more counselors and other special personnel in the schools? Should we add trained child welfare workers in the Welfare Department? Should we add to the Health Department staff—if so, should it be more nurses or psychologists and social workers. Should we first add professional staff to the juvenile court? Or should we forget all these and spend more on recreation?" At the state level, I do not believe we have the answer to these questions. I believe this calls for a good hard look by those sharing responsibility at a local level. The physicians in the community can offer invaluable help and leadership, in planning program development locally that goes beyond medical functions. I know this is asking a lot when you may be constantly frustrated with the lack of facilities and specialists to which to refer your own patients. But this is a responsibility that must be met.

This is particularly true as the current nationwide planning for mental health continues at state and local level. Who can help clarify the concepts of what will be involved in your community in the development of Comprehensive Community Mental Health Services? Here is an important function of the physician in the long-range contribution to the emotional wellness of your people. Many of the things that need to be done to assure emotional wellness go beyond the medical functions. Responsibility is shared by schools, churches, homes, family and welfare services, correctional services and police and courts, and all the organized helping functions in our society.

Summary

The physician's opportunity covers, then, a tremendously broad spectrum: 1) the individual treatment of patients and other things you do yourself, 2) the many things you do cooperatively with others, and 3) the things that you can help guide or inspire others to do. These three levels apply both to persons already sick and to the total population whose health must be protected, and whose creative and productive capacities must be developed in more effective ways.

We began with a reference to an experiment which succeeded in a private cooperative venture for immunizing a total population. One idea had been that the public health agency would have to do the job in order to assure adequate coverage of the population. In many ways it is being demonstrated that people can take over private responsibility for action related to their health. It is not a matter of demonstrating privately how something can be done and then turning it over to tax-supported programs to operate. It works both ways. Some things demonstrated by public programs can be taken over by well-organized private arrangement, with voluntary citizen cooperation. This challenge confronts us in the field of mental health. Mental illness has almost been relegated as a state responsibility, but we are now awake to the fallacy of this idea. The physicians of this country can and will meet this challenge, for there are multiple values at stake. We are concerned with more than the treatment of sick individuals, as vital as that is. We know that beyond the care for the sick and the

(Continued on Page 448)

The Problem of the Dizzy Patient†

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Dizziness may mean: weakness, confusion, anxiety, syncope, or vertigo, and has various causes. To help these patients, a classification of dizziness and plan of approach to its diagnosis and management is essential.

DIZZINESS is one of the more common symptoms which brings a patient to his physician. This symptom is a problem to the patient because it interferes with his activity and sense of security. It is a problem to his physician because of the wide variety of symptoms included in the term "dizziness" and the number of causes of such symptoms. In order to help these patients one must have a classification of dizziness and some plan of approach in its diagnosis and management.

The history is important. What does the patient mean by dizziness? Is he weak? Anxious? Has he lost consciousness? Fallen? Become nauseated, or has he had a false sense of motion relative to his surroundings? All of these symptoms are either the result of a disturbance of equilibrium or of sensorium.

Vertigo is a sensation of movement, it may be in any direction, rotatory or linear or antigravity. It must be differentiated from faintness, giddiness, weakness and disturbance in gait or vision.

Numerous sensory pathways aid in maintaining equilibrium, but by far the most important of these is the vestibular system, consisting of the equilibritory labyrinth, vestibular nerve, nuclei and their central pathways. A disturbance of this system produces the most severe types of vertigo.

Vertigo

Vertigo of peripheral origin is due to a disturbance of the inner ear, is usually severe, and generally accompanied by auditory phenomena, nystagmus, and nausea and vomiting.

Acute and chronic otitis media and mastoiditis are common and obvious causes of vertigo. An inactive cholesteatoma of the middle ear and mastoid should not be overlooked and may be accompanied by a labyrinthine fistula.

Toxic neurolabyrinthitis may be of viral origin or induced by drugs, i.e., alcohol, barbiturates, quinine and streptomycin. This condition is readily diagnosed and is self limited.

The vast majority of patients with true vertigo have some interference with labyrinthine blood supply; hence the popularity of vasodilating drugs in the treatment of vertigo. An "ear stroke" is a very dramatic affair and is due to an abrupt deprivation of blood from the inner ear; it may be due to a thrombus, embolus or hemorrhage and may involve the entire inner ear or only the cochlea or the vestibular labyrinth. The patient is seized with sudden vertigo, nausea and vomiting, and if the cochlea is involved a roaring tinnitus and profound deafness in the affected ear, any movement of the head produces more severe symptoms, nystagmus and pastpointing are present. Symptoms slowly subside over a period of two to four weeks but mild vertigo on change of position persists for several months. The patient is left with a loss of function of the involved ear. Treatment consists of strong reassurance, sedation, and time. Vasodilating drugs are indicated with the hope of re-establishing labyrinthine blood supply.

Meniere's disease (endolymphatic hydrops) is felt to be due to a spasm in the arterioles in the stria vascularis of the cochlea. This causes an excessive production of endolymph. Symptoms consist of recurring attacks of vertigo, nausea and vomiting, deafness and tinnitus lasting 30 minutes to several days. Most attacks are over in an hour or so. The hearing often returns to normal between attacks, but as the disease progresses the hearing in the affected ear worsens and eventually the patient becomes quite deaf in that ear. Medical treatment of Meniere's disease is directed toward prevention of the excessive formation of endolymph

† *Presented October 1, 1964 at the General Scientific Session of the Kentucky Medical Association Annual Meeting in Louisville.*
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by the use of vasodilating drugs, avoidance of cafeine and nicotine, an understanding of the emotional aspects of the illness, and depletion of excess fluid by the use of diuretics and diet. Surgical treatment of Meniere's disease is reserved for those patients with severe symptoms which do not respond to a medical regimen and who have no useful hearing in the affected ear. "Shunt" operations and the use of ultrasonics in an effort to salvage hearing are interesting, but in my opinion the operation of choice is still a destructive labyrinthotomy done by the stapes approach.

Other Causes

Numerous inner ear vascular syndromes of lesser degree are common and generally respond readily to a Meniere's regimen of treatment.

Acoustic neuromas and other cerebellopontine angle tumors produce unilateral nerve deafness, tinnitus, and ataxia but rarely produce episodic vertigo. Corneal anesthesia due to fifth cranial nerve involvement is an early sign in these patients.

Vertigo of central origin is not as severe as that of peripheral origin but is much more common. It is characterized by momentary bouts of vertigo on change of position. These patients tend to be subject to vertigo on certain movements for a period of several months. The symptom leaves and may never return, or more commonly several such bouts will occur over a period of several years. Cerebral ischemia and petechial hemorrhages along the vestibular pathways are felt to be the cause of this syndrome. Vasodilating drugs are commonly used although they are of questionable value. Sedation, reassurance, and motion sickness drugs, i.e., Dramamine®, Bonine®, and Merizine® are of value.

Head injury often produces positional vertigo for many months as a part of the "post concussion syndrome." Positional nystagmus may be demonstrated in these patients.

Hypertension produces dizziness and a lightheaded feeling rather than true vertigo.

Vertigo similar to that seen in Meniere's disease may be an early symptom of multiple sclerosis, and is occasionally seen as an aura in migraine.

Psychogenic dizziness is due to anxiety. Weakness, fainting, visual disturbances, etc., all must be considered in any differential diagnosis of vertigo.

Summary

An approach to the diagnosis and management of the patient with dizziness has been given. The importance of various inner ear vascular syndromes in the production of vertigo has been stressed.

Plan Ahead

to attend the

KMA 1965 Annual Meeting

in Louisville

September 21, 22, 23

CASE DISCUSSIONS
From The
University of Kentucky Hospitals

Adverse Reaction of Intravenous Urography In Multiple Myeloma

H. D. Rosenbaum, M.D.,* E. J. Lappat, M.D.,** and Madison Cawein, M.D.***

Introduction

During the past ten years there have been several reports[1,2,3,4] of untoward, usually fatal, reactions to intravenous urography in patients with multiple myeloma. These reactions have been characterized by a decrease in urine output, often anuria, with resulting uremia. Death has occurred within several days or months following the x-ray examination.

Case Report

S. B., a 62 year old white married female, was admitted to the University of Kentucky Medical Center on June 15, 1964, complaining of "arthritis."

During the six months preceding admission the patient had been troubled by stiffness and pain in her knees, fingers and back. From time to time the knees had been swollen but not tender. Decreasing appetite with an unknown amount of weight loss occurred during the present illness. All of the patient's symptoms progressed despite various medications, eventually leading to hospitalization in a nearby hospital during the two weeks preceding the current admission. At that time she was told her "blood was low" and given three transfusions. Upon discharge from the outlying hospital the joint pains increased, her appetite remained poor and weakness progressed until she could no longer be up and about.

Throughout the years the patient had enjoyed excellent health except for minor allergies and a vague history of hypertension of unknown proportions which had caused no symptoms. There was a strong family history of hypertension.

Physical examination on admission revealed a blood pressure of 140/80 and a regular pulse of 96. No acute distress was evident. A moderate kyphosis was present and mild swelling of the left knee and the interphalangeal joints was apparent. A grade II apical systolic murmur was recorded. There was questionable tenderness in the costovertebral angles bilaterally. The examination was otherwise within normal limits.



FIGURE 1. The preliminary scout film (A) taken prior to injection of opaque medium shows the kidneys faintly outlined. Six hours after administration of the contrast agent (B) a dense nephrogram is present bilaterally.

The initial impression was that the patient was possibly suffering from rheumatoid arthritis and appropriate studies were initiated. The latex agglutination test was weakly positive. Films of the hands revealed nonspecific generalized demineralization. The blood count showed a mild anemia. The hemoglobin was 10.2 gms.%, and the indices were normal. No abnormal cells were noted on the initial peripheral blood smear. The sedimentation rate was 38. A trace

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of protein and a rare white blood cell were reported on the admission urinalysis. An LE preparation was reported to be negative. The blood urea nitrogen on two occasions was 34 and 37 mgm.%. Other admission laboratory studies were non-contributory.

On the third hospital day an intravenous urogram was performed. Although a dense nephrogram appeared and persisted for many hours (Fig. 1) and opaque medium accumulated in the bladder, at no time were the caliceal systems or ureters identified. On the same day abnormal plasma cells were noted on a repeat LE preparation and in the peripheral blood. Subsequently, films of the skull (Fig. 2) and ribs showed characteristic myelomatous changes. Bone marrow studies were characteristic of multiple myeloma. At no time was Bence Jones protein found in the urine.

The patient experienced a steadily downhill course following the intravenous urogram. Urine output decreased. Nausea and vomiting became an increasing problem. As the BUN ascended to near 100 the patient became less responsive. Despite vigorous therapy, including intravenous fluids and phenylalanine mustard, the patient's condition worsened. By one week after the intravenous urogram, abundant moist rales were present in both lung fields. As marked depression of urinary excretion continued the patient lapsed into coma and expired eight days after the intravenous urogram. No autopsy was obtained.

Comment

It is well known that multiple myeloma commonly impairs renal function. In fact, uremia is second only to pneumonia as the cause of death in this disease. Kidney damage may occur in a variety of ways: by plasma cell infiltration of the renal parenchyma, by a direct toxic effect of Bence Jones protein on the tubular cells, and by precipitation of protein within the renal tubules. Bell[5], in 1933, was the first to suggest that the kidney damage in multiple myeloma was secondary to deposits of abnormal proteins in the renal tubules. Extensive deposition of protein casts in the tubules leads to mechanical obstruction with secondary glomerular atrophy. This point of view has received support from autopsy studies which have shown characteristic large, amorphous protein casts in the renal tubules surrounded by degenerated tubular cell nuclei which present the appearance of giant cells.

Multiple myeloma not infrequently presents as renal disease. Clinical manifestations of the renal disease may be bizarre and mimic many types of kidney disorders. Symptoms and signs of renal disease are not infrequently present without overt characteristic evidence of myeloma. This occult form of myeloma may, unfortunately, lead to intravenous urography subjecting the patient to the danger of acute anuria.

The usual preparation for intravenous urography involves cleansing cathartics and dehydration by fasting. This obviously sets the stage for precipitation of protein material in the tubules, since tubular urine is concentrated under these conditions. The injection of the contrast material preferentially excreted by



FIGURE 2. Characteristic punched-out destructive lesions of multiple myeloma shown on a lateral skull film.

the kidneys adds an additional acute, perhaps toxic, burden to the diseased, dehydrated myelomatous kidneys. This additional insult apparently provides the initiating factor which effects acute deposition of the abnormal proteins in the renal tubules with resulting oliguria or anuria.

It is of some interest that anuria has followed intravenous urography in the absence of Bence Jones proteinuria. None of the previous reports have recorded a persistent nephrographic phase of the intravenous urogram shown in this study. The duration of the nephrogram in this case suggests that a quantity of the opaque material was deposited in the renal tubules along with the abnormal protein. It is generally accepted that the nephrogram results from the presence of opaque medium in the renal tubules. A follow-up film taken four days later still showed a faint suggestion of a nephrogram bilaterally.

There is no question that intravenous urography should be avoided in patients with known multiple myeloma. This presents no problem in cases where the diagnosis is obvious. Unfortunately, the diagnosis may be quite obscure on admission. It is not unusual for myeloma to present in many forms. An initial complaint of "arthritis" and anemia, as in the case reported above, is quite frequent. The not uncommon presence of renal symptomatology may, unfortunately, lead the clinician to consider intravenous urography as an appropriate examination. It is in such occult cases of multiple myeloma that intravenous urography is most commonly performed. Any suggestion of myeloma, such as anemia, disproteinemia, elevated serum calcium, renal signs and symptoms should alert the attending physician to the possibility of this entity and lead to a delay in the intravenous urogram until myeloma can be confirmed or excluded.

Summary

A 62 year old white female was examined by intravenous urography before a diagnosis of multiple

(Continued on Page 451)

SPECIAL ARTICLES

Services in Blindness and Prevention of Blindness In Jefferson County, Kentucky†

M. M. Slusher, M.D. and A. H. Keeney, M.D.

Introduction

THIS study analyzes the methods by which Jefferson County, Kentucky, (including Louisville) manages problems in the prevention of blindness and services for the blind. Both categories include programs available on a state-wide level, but because of their locale in Louisville, many are more a facility for Jefferson County than for the state. There are an estimated 1,330 blind persons in the county. Of these, 666 are 65 years or older while 1333 are under the age of 21 years.*

Preventive Services

1. *Children's Hospital Eye Clinic:* Opened in 1957, this is the only clinic of its type in Kentucky and serves the entire state. Since 1961 it has been financed by the Commission for Handicapped Children. Appointments are made by health officers or private physicians, and no one under 16 may be denied initial visit. Unless there is medical indigency, subsequent care must be arranged privately.

According to law, there can be no preliminary social service screening, therefore, "private" patients could abuse this service. The commission is reluctant to refer patients to community ophthalmologists for follow-up. This sometimes imposes a travel burden where local physicians could handle follow-ups with ease and economy.

Residents from the University of Louisville Department of Ophthalmology and volunteer faculty ophthalmologists attend all clinics and surgical procedures.

In 1963, 1,719 patients were served and 135 operations performed. Spectacles, contact lenses and artificial eyes are supplied at cost by Medical Center Opticians, an incorporation not-for-profit founded in 1957 by the Guild Opticians of Louisville. In 1963 they handled 318 children at an average cost of $7.11 per child (excluding the gratuitous man hours and equipment) and have been reimbursed for all but $185 of this.

2. *Louisville General Hospital Eye Clinic:* Most local indigents are served here. In 1963, 6,356 patients were treated, including 2,366 refractive examinations, nearly 600 squint cases and nearly 600 glaucoma cases. Daily clinics are operated by the resident staff, under volunteer faculty supervision.

3. *Pre-School and School Screening Clinics:* The pre-school program is nine years old, but 1964 is the first year in which three-year-olds were screened. This program started as a project of the Delta Gamma Sorority but has come under auspices of the National Society for the Prevention of Blindness.

In 1963-64, 4,077 children were screened[1], and 307 (7.5%) with subnormal acuity or apparent eye defects were referred for further study. Eighty-one delayed responses from parents received public health nurse follow-ups.

In-school sceening is done by the P.T.A. with similar referrals but here the volunteer parents change frequently and program continuity is difficult. Parents of pre-schoolers must pay for glasses (though if indigent, examination is free at the Louisville General Hospital), as opposed to the needy school age children who are eligible for aid. Local funds are managed by a health nurse and contribute eleven dollars to the cost of the glasses, two of which are refunded by the optician to the original fund.

This project has reached over 29,000 children but with the increasing estimates of 16,000 to 20,000 pre-schoolers each year, the number of screening teams must be increased beyond the present dozen.

The cost of glasses and delay in procurement are recurring problems. New Eyes for the Needy (Short Hills, N.J.) has been progressively generous in financing glasses and now contributes $1,200 a year through General Hopital. This charity is unique in refusing to accept any money but accepts all types of old spectacles, jewelry or dentures. Reuseable frames and simple lenses are sorted. Safety goggles have been provided to local school shops without charge.

The Sight Saving Association of Louisville, incorporated not-for-profit in 1936 was endowed by an un-

† *This material was submitted and accepted in part as thesis requirement for graduation (M. M. Slusher) by the Department of Community Medicine, University of Kentucky, School of Medicine.*

* *Report on Services for the Blind in Jefferson County, Kentucky, Louisville Community Chest, Health & Welfare Council, Nov. 1960, pp. 20.*

[1] *Nearly 1/3 of these come from low income groups.*

known benefactor but receives gifts from other sources[2]. Indigent children failing school screening tests are visited by the school nurse and, with parental consent, are referred to Louisville General Hospital for eye examination. Indicated glasses are furnished at cost by local opticians, and the charges met totally or in part by the Association.

One Guild Optician extends a Christmas credit to each ophthalmologist in the community, and this is used to furnish spectacles to the needy on request.

4. *Kentucky Society for the Prevention of Blindness:* This volunteer agency was initiated by Linda Neville, of Lexington, in 1911. It and "The Mountain Fund" were the vehicles through which Miss Neville directed her life in the conquest of trachoma and ophthalmia neonatorum. The Society was dormant for a few decades prior to World War II but was recrystallized in the 1950's by C. Dwight Townes, M.D., and the National Society for the Prevention of Blindness. The Kentucky Society is a component of the National Society and is directed by Mrs. Edgar Read in Louisville. It sponsored, at the 1962 State Fair, the first mass screening for glaucoma in Kentucky. Additional screenings have been conducted in a half dozen other communities and at the fair in 1963 and 1964. The society sponsors the Wise Owl Clubs in industry and the Junior Wise Owl Clubs for those whose sight has been saved by safety glasses. Free educational materials and lectures are offered by the director or board members. It is largely self-sustaining through local gifts and its annual September drive, "Sight Saving Month".

5. *The Kentucky Lions Eye Foundation:* This brings together many traditional Lions activities in prevention of blindness. In 1957, the Lions opened a Friday morning problem eye clinic and the Lions Eye Bank, which have been staffed and housed by the University of Louisville. Indigent cases may be referred from any Lions Club. Lions contribute about $15,000 annually to services and teaching programs of the Eye Bank. A Research Institute in conjunction with General Hospital is now in the stage of funding.

Services for the Blind—State and Local

1. *Aid for Needy Blind:* In fiscal 1963-64, payments totalling $1,859,559 were distributed to about 2,400 recipients. The Social Security Administration supplies three dollars to each one dollar Kentucky provides through the Department of Economic Security. Kentuckians are eligible if their visual fields are reduced to 20° or less or if central acuity in the better eye is 20/200 or less with optimal refractive correction. Money is awarded according to need with deductions for other income. The average individual monthly grant (1960) was $60.46 in Jefferson County, versus $51.93 in the entire state. In the Louisville office, this program is administered by 19 social workers.

Public Assistance recipients under Aid to the Needy Blind may obtain an additional ten dollars per month for dog food which is not available under the Old Age and Survivors program. This, in part, has reversed a trend to transfer beneficiaries older than 65 from Aid to Needy Blind to Old Age Survivors Assistance.

2. *Bureau of Rehabilitation, Services for the Blind:* This service, under the Department of Education, provides primarily (a) for adjustment to life, travel instruction and job preparation, (b) preparation for competitive employment in sheltered workshops, or (c) jobs when other work is not available.

In 1959-60, at least 89 persons, blind in both or one eye, received services up to and including college tuition. In 1963, 7 persons from the Kentucky School for the Blind were placed in positions. Facilities of the Kentucky Business Enterprises Program, the University of Louisville, the Fries Piano Hospital and the Louisville Academy of Music are used. The service may provide telescopic and microscopic visual aids enabling a "legally" blind person (i.e. central acuity of 20/200 or less with best conventional spectacles) to accomplish sighted work as assembling auto starters.

A home teaching program is provided in the Louisville area, particularly for the newly blinded adult.

This program absorbs a few patients on the basis of poor visual prognosis, but this is not stressed due to budget restrictions, though staff workers have been increased by more than 40% in the last four years.

3. *Kentucky Industries for the Blind:* After nearly fifty years under the Kentucky School for the Blind, this service in 1956 became a subdivision of the Rehabilitation Services of the Department of Education. It offers vocational training, employment, and distribution of Talking Book Machines. The agency is 85% self suporting, the other 15% coming from state funds. Twenty-seven blind individuals are employed full-time, and 90 part-time. Mops, brooms, bags, textile items and Christmas decanters are made. Training is offered in use of hand tools, factory parts assembly, industrial processes, sheet metal and woodworking, as well as operation of machine shop equipment. Since 1957, women have been included in this program. Annual sales total approximately $250,000 with $82,000 paid to employees.

Talking Book Machine distribution and service began in 1934. Portable record players are provided to applicants certified by their ophthalmologists. These play Talking Book literature on LP records. The Postal Department handles such records without charge. Approximately 1,200 individuals in Kentucky use these aids.

4. *Louisville Free Public Library:* This library is the largest in the South and is one of only two libraries in the South to own and operate FM stations. A unique service for the visually limited is the Nettleroth Children's Collection of 200 enlarged-print books and over 100 "libraphone" records of prose costing approximately $2,000.

The least utilized facility the library offers the blind is its audio section. This is the transmitting site for 50 closed circuit telephone lines, renting for five dollars per month per air mile. The University of Louisville, a few Jefferson County schools and all branch libraries have lines. Receiving stations merely request desired tapes to be played. Approximately 40,000 tapes are available in wide selections. The School for the Blind does not utilize these tapes,

[2] *Louisville Foundation, P.T.A., Lions. etc.*

which are also available through earphones within the library.

The two FM radio stations offer a variety of non-musical programs and fifty FM radios are available from the library at rentals of about three dollars per month.

5. *American Printing House for the Blind* (Founded 1858): This printing house is the largest of its kind in the world. Primarily, it makes books and records for the Library of Congress. In addition to braille texts and novels, it prints and records Reader's Digest and Newsweek. In 1963, it printed 297,435 braille volumes and pamphlets, and 39,240 large type volumes.

This corporation also contributes through its Educational Research Committee, investigating problems as: Training to Increase Braille Reading Speed; Perception in Braille Reading; Analysis of Visual Abilities, and Modes of Reading in Blind Children.

In 1964, a joint project with I.B.M. evolved the first electronic or automated production of Braille texts. This yields huge savings in production time and ultimately in cost.

The Printing House has recorded over 2,000 works of prose and poetry at approximately half the cost of braille. The 15 to 20 blind employees proof read in braille-to-record translation, or operate production equipment.

6. *The Kentucky School for the Blind:* This school was established by the state legislature in 1842. Classical and landmark architecture of this domed building has checkreined plant modernization, but major new buildings were achieved in 1964. The budget of approximately $320,000 comes entirely from state funds. Per capita cost of educating the currently-enrolled 161 students is around $2,000 per year. One hundred fourteen students live in the dormitories. The remaining 47 are day students. Twenty-one teachers afford a teacher-student ratio of about 1:8. The ratio of house parents to students is 1:40. There is one health nurse.

Student intake on a statewide basis is below expectancy figures. The high proportion of Jefferson County students reflects both the population of this county and also families who move nearby so children may be day students.

Admitting eye examinations and most eye care is furnished through the General Hospital Eye Clinic. Private ophthalmic care may be elected.

Understanding and interchange between the school and the ophthalmic community should be strengthened by meetings once or twice each year. Ophthalmologists, pediatricians and family physicians are often unaware of problems in educating the blind. Medical students and resident physicians should have exposure to this educational equipment and processes.

7. *Information Center for the Chronically Ill:* This two-year-old volunteer agency is sponsored by the United Appeal, U.S.P.H.S., state and county departments of health and "forty cooperating agencies". The center will direct the chronically ill through the maze of volunteer and over-lapping governmental services. Significant statistics are not yet available, but only a few blind persons have been served. A Home-Aide Service of visiting personnel to organize service to patients in the home is being developed.

This service can develop valuable in-home-care and training for the newly blind prior to rehabilitation programs.

8. *Governor's Advisory Committee:* In July, 1964, Governor Breathitt indicated concern for utilization of the blind by appointing a new group to serve for two years in this area. There is much constructive action to be channeled into better education for those with sight, better case finding and more productive contacts for the Kentucky Industries.

Conclusions

Many service agencies including some blind individuals in their overall programs are intentionally omitted from this study. The organizations described, however, picture well the unique spirit of American volunteerism.

The multiple organizations meeting special problems and the procedural requirements of government agencies have made necessary the Information Center for the Chronically Ill. There is inadequate understanding among professional groups striving toward similar objectives. Some facilities exist unknown to workers in the same area. This is particularly seen in supplying spectacles and ocular aids to children. Changing personnel and procedures soon exceed usefulness of reports such as this or the 1960 survey. Medical students, eye residents and social work students should have formal introductions to these areas. Practicing ophthalmologists, health officers, pediatricians and agency workers should have annual opportunities for interchange, successively sponsored by different professional groups involved in blindness.

Healthy growth of services, teaching and research are best assured by balanced participation in the teaching areas by full-time and volunteer faculty or in the agency area by governmental or "official" bureaus and volunteer organizations.

EDITORIALS

New Concepts For Hospital Care

THE concepts of progressive patient care within a hospital and of regional planning for hospital care are ones that are attracting attention and provoking discussion in the medical profession.

Most of the articles concerning different aspects of patient care have appeared in hospital and nursing journals and in many cases have come to the attention of the practicing physician. In 1964, the University of Michigan press published an anthology, entitled: "Progressive Patient Care." It was edited by Lewis E. Weeks and John R. Griffith. The book represents a collection of discussions and reports on different aspects of progressive patient care by authorities in the health professions. The anthology provides the individual reader with much information and in addition an extensive bibliography on the subject.

With the progressive patient care concept the individual hospital is organized about the varying needs of different groups of patients. Patients within the hospital are grouped depending upon the amount of nursing and special care the patient requires. It is felt by the advocates of this plan that both patient care is provided in a more efficient and economical manner. The hospital may be divided into Intensive Care, Self Care, Intermediate and Long-Term Care units. A number of Kentucky hospitals have already instituted Intensive Care units and the general reaction of the practicing physicians seems to have been a favorable one.

Another new concept involving hospital committee for each individual hospital and that such a committee should have the medical planning was discussed at the Interim Meeting of the KMA in Owensboro by Nathan J. Stark, chairman of the Hospital Planning Council for the Kansas City Metropolitan Area. He pointed out that there had been a seeming resistance of some medical groups to the concept of community planning for hospitals and related health facilities such as nursing homes. However, in November 1962, the AMA passed a resolution affirming that areawide hospital planning on a voluntary basis is recognized as an imporant method of providing hospital facilities, that good planning can decrease the total cost of medical and hospital care, and prevent expensive duplication and that it is important for medical societies and individual physicians to cooperate and exert leadership in planning.

Areawide planning should be made to work on a voluntary basis and this isn't easy, as Stark points out, because it requires a personal commitment to carving out the objectives, and the ability to submerge individual interests to a broad over-view of community need. To acomplish this there is needed an understanding by physicians of the economics of hospital operation. In spite of the time spent in the hospitals, many of the practicing physicians have the vaguest kind of knowledge concerning the economics of hospital operation. It is pointed out that part of this has been due to the failure of the hospital boards and administrators to communicate this knowledge and information to their medical staffs. It was Stark's recommendation that there first needs to be a planning

staff represented on it. Beyond this there is a need to approach hospital planning on a metropolitan regional basis to assure that all new and modern services are provided without unnecessary and expensive duplication.

The AMA, in a new publication called, "A Look at Hospital Construction," proposes the following: "What is needed is a blue print developed by local community leaders, and especially physicians, so that medical facilities and services are planned and used properly, professional and skilled personnel are used efficiently and costly institutional accommodations are not constructed when not really needed. The community has the responsibility for creating and maintaining adequate health facilities to meet the needs of its people, but it cannot fulfill that responsibility without the help of the community's physicians."

WALTER S. COE, M.D.

What Can We Do About It?

THE Kentucky Chamber of Commerce has recently prepared and distributed a booklet entitled "How You Can Hold Down the Rising Costs of Hospital Care." Copies for personal use and distribution may be obtained by writing to the office of the Chamber, Third and York Streets, Louisville, Kentucky. A supply for free distribution in the physician's reception room will prove acceptable reading to patients and perhaps encourage cooperation in the solution of this problem.

Medical care prices have risen 39% in the last ten years. This is far above the percentage rise in general living cost. Direct fees to physicians account for only 29% of total health care cost, but the doctor's key position in the provision of medical care renders him an important factor in its control. The physician determines whether a patient is to be treated in the hospital, home or office. A critical review by competent persons has indicated that from 5% to 20% of hospital admissions are actually unnecessary. They are in many instances initiated by the demand of the patient or his family rather than by the physician's decision. This is a recurring and difficult problem in our practice and requires a reasonable scrutiny of each prospective hospital patient as to the actual necessity for his admission.

The physician determines in a large measure the length of stay required. It has repeatedly been shown by insurance agencies and Blue Cross that one additional day of hospital stay is a very important and often critical factor in the rate schedules required. We often meet with the patient's reluctance to be discharged at a time when we feel that the necessary hospital care has been accomplished. We are also confronted with the constant possibility that discharging a patient "too soon" carries with it some medical, ethical and even legal implications.

The physician determines the type and amount of laboratory and x-ray examination, drugs, and physical therapy to be used. If these services are ordered in excess of reasonable need for the patient's welfare, we have added significantly to the rising costs of medical care.

In one study presented from a representative group of hospitals in the ten year period from 1954 to 1963 there was an increase of 17% in the patient days in the hospital, an increase of 52% in the x-ray examinations made and an increase of 153% in the laboratory services rendered. It would appear that the physician could well exercise greater care in the selection of x-ray examinations and laboratory studies actually needed.

The promptness with which the physician initiates diagnostic studies after the patient's ad-

mission and with which desired consultations are accomplished are very important in the length of hospital stay. This matter is complicated by the inability to obtain these services over weekend or holiday periods, but with diligent care can be greatly improved.

Insurance policies of commercial companies and Blue Cross are usually not designed to cover diagnostic services for complaints not related to the illness for which the patient was admitted. We often yield to the patient's desire to have a thorough-going investigation of all of his complaints when he has been hospitalized for an acute illness. This is an abuse which all of us find it difficult to prevent.

Contained in a Newsletter from Martin E. Segal Company in April is a tabulation of admissions to general hospitals during 1963. The country is divided into 9 geographical areas. In the East South Central area, which includes Alabama, Kentucky, Mississippi and Tennessee, we are second from the lowest in the hospital days per 1,000 population. We are second from lowest in the length of stay of patients in the hospital—the lowest average is 6.5 days, our average being 6.7 days, the highest average is 9.3 days. We are fourth from lowest, better than the average, in the admissions per 100,000 population. It is reassuring to learn that in these respects at least we are doing better than the country at large.

The American Medical Association and the Kentucky Medical Association, among others, have long encouraged the establishment of Admission and Review Committees in every accredited hospital in order to provide the best possible experience in the matters contained in this discussion. Our own personal observation in the operation of such a committee in a single hospital and the operation of these committees in hospitals distributed over the state indicates their great value. Careful and systematic cooperation with such a committee in the hospital can significantly improve its experience with respect to unnecessary admissions, abuse of diagnostic facilities, and particularly in the unnecessary length of stay. If we as physicians are to work effectively in the control of the costs of medical care such systematic review of our own operations is essential.

At the 15th Annual Interim Meeting of the KMA at Owensboro, Mr. Nathan J. Stark, chairman of the Hospital Planning Council in the Kansas City Metropolitan Area, presented a very comprehensive and clear picture of the value of hospital planning councils especially for the larger communities. This activity has been sponsored by the Louisville Chamber of Commerce and is now being established with the cooperation of the Medical Society and Hospital Association. It seems clear that a community having more hospital beds than necessary encourages over-utilization of hospital care and thereby contributes to the rising cost. It is also apparent that duplication of the more expensive highly specialized operations in one community tends to increase the general cost of medical care. This work is being sponsored primarily by non medical civic leaders in the community. It is hoped, however, that Mr. Stark's advice to utilize the experience and counsel of physicians and hospital administrators will be used to the greatest advantage.

The whole problem of the rising cost of hospital care is one in which we as physicians and citizens are vitally concerned. We can do much to help in its solution.

SAM A. OVERSTREET, M.D.

ORGANIZATION SECTION

Top Scientific Talent Engaged For 1965 Annual Meeting

Stressing the postgraduate educational benefits of the 1965 KMA Annual Meeting in September, Delmas M. Clardy, M.D., Hopkinsville, president of the Association, urged all Kentucky physicians to attend this important meeting.

An impressive group of 16 guest speakers will come to Louisville on September 21, 22, and 23 to participate in an outstanding scientific program, Doctor Clardy said. He recently released the names of four featured speakers who will participate in the general sessions as the guests of various specialty groups.

H. Marvin Pollard, M.D., professor of internal medicine and head of the section on gastroenterology at the University of Michigan Medical School at Ann Arbor, will be the guest of the Kentucky Chapter of the American College of Physicians.



Doctor Pollard

Doctor Pollard will participate in the Thursday morning general session, presenting a discussion of "Late Complications of Gastric Surgery for Peptic Ulcer", and will take part that afternoon in the scientific meeting of his host group.

He is a former governor for Michigan of the ACP, and is currently serving as ACP regent. Doctor Pollard is also a past president of the American Gastroenterological Association, and is now chairman of the sub-specialty Board of Gastroenterology.

Leonard M. Schuman, M.D., professor of epidemiology at the School of Public Health at the University of Minnesota, will be the guest of the Kentucky Association of Public Health Physicians during the annual meeting. He will also appear on the program of the general session on Thursday morning, September 23, with a discussion not yet announced. His topic at the meeting of the Public Health Physicians that afternoon will be "The Epidemiology of Chronic Disease and its Public Health Applications."



Doctor Schuman

Doctor Schuman received his M.D. degree from Western Reserve University. He served as chief of the Division of Veneral Disease Control; acting chief of the Division of Communicable Diseases; and deputy director of the Division of Preventive Medicine, all within the Illinois Department of Public Health, before going to Michigan.

Mildred Stahlman, M.D., is assistant professor of pediatrics at Vanderbilt University School of Medicine, a post she has held since 1958. Doctor Stahlman, who will be the guest of the Kentucky Chapter of the American Academy of Pediatrics, will take part in the Tuesday morning, September 21, general scientific session representing the pediatrician's point of view in a panel discussion on "Respiratory Disease in the Newborn".



Doctor Stahlman

Doctor Stahlman will talk on "Cardiovascular Assessment of Infants with Hyaline Membrane Disease" before her host group that afternoon. She is a 1946 graduate of the Vanderbilt School of Medicine. Doctor Stahlman, who previously held the post of assistant professor of physiology at Vanderbilt in addition to her current appointment, is a former president of the Southern Society for Pediatric Research.

Stewart G. Wolf, M.D., professor and head of the department of Medicine at the University of Oklahoma School of Medicine, will be the guest of the Kentucky Psychiatric Association at the KMA Annual Meeting.



Doctor Wolf

He will participate in a general session panel discussion on "Peptic Ulcer" on Thursday morning, presenting the psychiatrist's viewpoint. His topic that afternoon at the meeting of his host specialty group has not yet been announced.

Doctor Wolf, who currently serves as consultant professor of neurology and psychiatry and head of the psychosomatic and neuromuscular section of the Oklahoma Medical Research Foundation, is a past

president of the American Federation for Clinical Research and the American Psychosomatic Society. He is a 1938 graduate of Johns Hopkins University School of Medicine.

Additional information on guest speakers will be presented in later issues of The Journal.



Doctor Sirkle



Doctor Perry

Dr. Sirkle Elected to Head KAGP; Academy Honors Dr. Perry

Robert M. Sirkle, M.D., Lexington, was named president-elect of the Kentucky Academy of General Practice during the KAGP annual meeting in Louisville May 5-7.

He will take office next year, succeeding Carroll L. Witten, M.D., Louisville, who was installed as president at the May meeting.

T. M. Perry, M.D., Jenkins, received the Academy's annual "Citizen-Doctor of the Year" award in recognition of his 36 years of general practice in Letcher County.

The meeting, held at the Kentucky Hotel, was attended by physicians from all parts of the state, who heard scientific presentations by nine outstanding guest lecturers from a variety of medical specialty fields.

Doctor Sirkle, who has served for several years as secretary of the Academy, is a past president and secretary of the Floyd County Medical Society. He had practiced in Floyd County from 1945 until moving to Lexington in 1956. He is an alternate delegate from the KAGP to the American Academy. Doctor Sirkle graduated in 1939 from the Eclectic Medical College of Cincinnati.

Doctor Perry has been president of the Letcher County Medical Society for about 10 years, and chairman of the local school board for eight years. He has served as a member of the State Board of Health and has been a Kiwanian for twenty years. He received a "Citizen of the Year" award from the Jenkins chapter of the American Legion in 1963. Doctor Perry has been active in county political affairs for many years.

Doctor Perry, a graduate of the University of Cincinnati College of Medicine in 1927, began practice at Jenkins in 1929.

Belle of Louisville Cruise Set For Alum Reunions at Meeting

University of Louisville Medical School Alumni will once more take to the river on the Belle of Louisville for a reunion September 21 during the KMA Annual Meeting, according to Les Shively, director of Alumni Relations at the University.

Ten five-year classes will hold reunions again this year. The class of 1915 is celebrating its 50th anniversary this year, and the class of 1930, its 25th.

A delicious buffet dinner and dancing to the music of Jeannie Crume and her orchestra is included in the price of the tickets, which will be announced later. The Belle, one of the few remaining sternwheelers in the country, is scheduled to leave the Fourth Street dock at 6:00 p.m. and return at 10:00 p.m.

Because of the success of last year's cruise, the first, you are urged to make your reservations early through Mr. Shively.

For additional information on individual luncheons and dinners that may be planned for your class, contact your chairman listed below:

1915—No chairman.

1920—To be announced

1925—To be announced

1930—Clifford Wilson, M.D., Kansas City, Mo. (Co-chairman Richard R. Slucher, M.D., Louisville.)

1935—Paul Mapother, M.D., Louisville.

1940—Edwin P. Scott, M.D., Louisville.

1945—Robert B. Nolan, M.D., Louisville.

1950—Hoyt D. Gardner, M.D., Louisville.

1955—C. Ray Potts, M.D., Louisville.

1960—David F. Archer, M.D., Louisville.

Phone Co. to Handle Messages

Once again the message center at the KMA Annual Meeting will be sponsored by the Southern Bell Telephone Company. This useful and popular service was provided for our membership last year.

Physicians may be reached while attending the 1965 Annual Meeting September 21, 22, and 23 at 584-2201 (Area Code 502).

KEMPAC Plans Seminar Sept. 20

Two nationally prominent speakers will be featured on the program of the seminar planned for Monday evening, September 20, by the Kentucky Educational Medical Political Action Committee to coincide with the 1965 KMA Annual Meeting.

The seminar, following a dinner and social hour, will be held in the Flag Room of the Kentucky Hotel in Louisville. Further information on both functions will be released in later issues of The Journal.

Dr. Noer Elected President of Ky. Surgical Society

Rudolf J. Noer, M.D., professor and chairman of the department of surgery of the University of Louisville School of Medicine, was elected president of the Kentucky Surgical Society during its two-day annual meeting in Louisville, May 14-15.



Doctor Noer

Doctor Noer succeeds Coleman C. Johnston, M.D., Lexington, in office. Herman E. Martin, M.D., Ashland, was elected vice-president, and secretary Blaine Lewis, M.D., Louisville, was re-elected to his second consecutive three-year term.

Robert J. Samp, M.D., assistant professor of surgery and director of the division of clinical oncology at the University of Wisconsin Medical Center, was the featured guest speaker during the meeting, held this year in cooperation with the University of Louisville department of surgery. Doctor Noer was in charge of the all-day program given by the department on Friday, May 14.

An excellent meeting, featuring a number of informative scientific presentations, was reported. The Society will hold its 1966 meeting at the French Lick Sheraton Hotel, French Lick, Ind., on May 13 and 14.

Joint Meeting Held in Somerset By 12th and 15th Districts

Delmas M. Clardy, M.D., Hopkinsville, KMA president, was among the featured speakers at the joint meeting of the KMA Twelfth and Fifteenth Trustee Districts June 2 at Somerset. His topic was "The Key to Socialism."

William W. Winternitz, M.D., associate professor of medicine, and Richard P. O'Neill, M.D., assistant professor of medicine, both of the University of Kentucky College of Medicine, presented the scientific program of the meeting, which was hosted by the Pulaski County Medical Society.

Doctor Winternitz discussed the "Complications of Diabetes," and Doctor O'Neill's subject was "Obstructive Airway Diseases."

Thomas O. Meredith, M.D., Harrodsburg, is trustee for the Twelfth District, and Robert E. Pennington, M.D., London, serves as trustee of the Fifteenth District. The meeting was held at the Beecher Hotel.

Pediatricians Elect Dr. Bushong

W. D. Bushong, M.D., Owensboro, headed the slate of officers elected by the Kentucky Pediatric Society at Ashland during the joint meeting of the Society with the Kentucky Chapter, American Academy of Pediatrics May 12-13.

Doctor Bushong succeeds Guy C. Cunningham, M.D., Ashland, as president. Also elected by the Society were Joan E. Rider, M.D., Lexington, vice-president, and John E. Bickel, M.D., Owensboro, secretary. Harry C. Shirkey, M.D., professor of pharmacy at Howard University, an authority on pediatic toxicology, was the featured speaker on the scientific program. An excellent meeting with record attendance was reported.

Ky. Public Health Assn. Names Dr. Gabbard President-Elect

Mildred B. Gabbard, M.D., Booneville, public health officer for Owsley, Lee, Clay and Jackson Counties, was chosen president-elect of the Kentucky Public Health Association during its April 20-22 annual session at the Kentucky Hotel in Louisville.



Doctor Gabbard

William Pickett, administrative assistant with the Hardin County Health Department, took office as president, succeeding B. F. Brown, M.D., Frankfort.

Doctor Gabbard, who is secretary of the Owsley County Medical Society, and a delegate to the KMA from her county, is a past president of the Kentucky Association of Public Health Physicians.

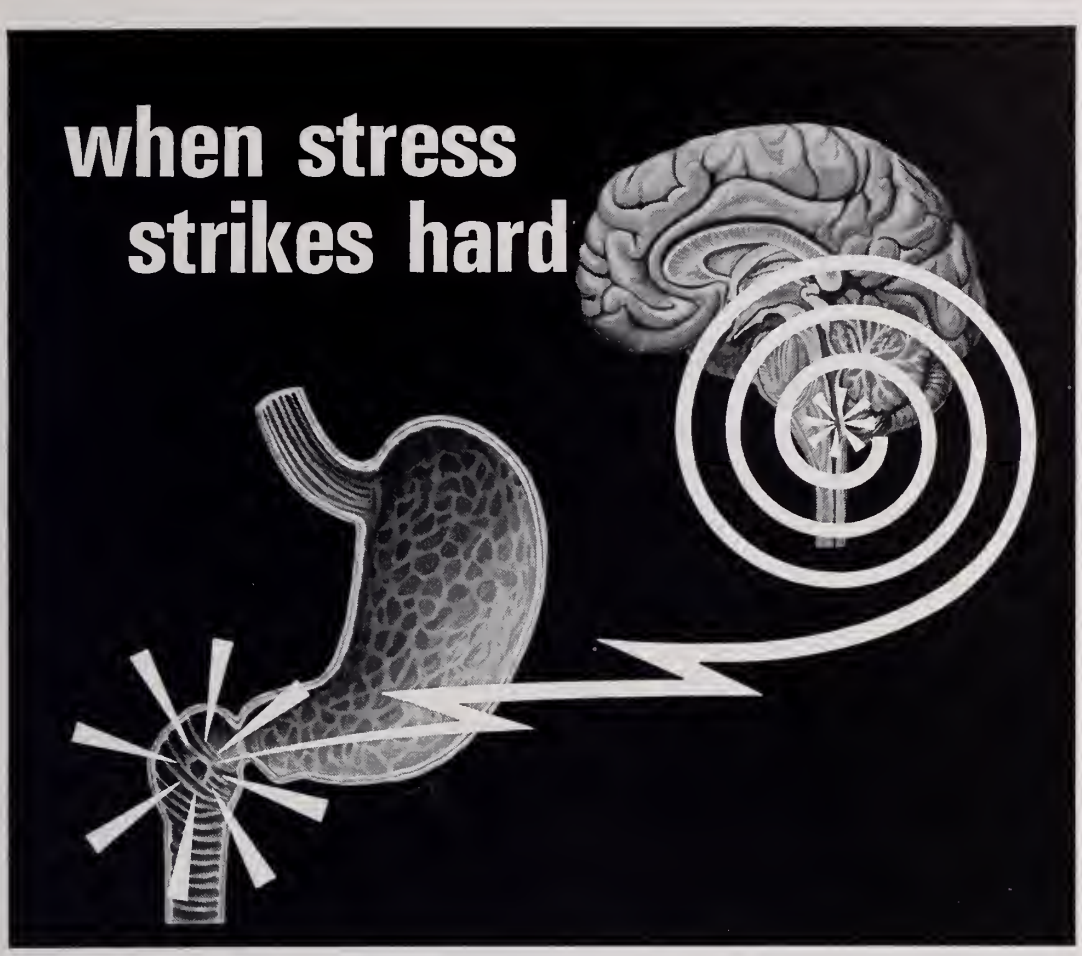
A graduate of the University of Louisville School Medicine in 1934, Doctor Gabbard spent five years in India as a medical missionary with the Methodist Church before returning to Kentucky as a public health physician. She practiced originally in Owsley County and later in Mercer and Washington Counties before returning to Eastern Kentucky to take her current office.

Walton Memorial Lecture Series Established by County Society

The Muhlenberg County Medical Society this year established an annual memorial lecture series in honor of the late John P. Walton, M.D., of Central City, a member of the organization for 56 years. The announcement was made by George F. Brockman, M.D., Greenville, Society secretary.

The first lecture was presented April 15 to physicians from eight Western Kentucky counties by Thomas R. Marshall, M.D., associate professor of radiology at the University of Louisville School of Medicine, who spoke on "Angiography in the Community Hospital." The meeting was held at the Greenville Country Club.

Doctor Walton, who was named General Practitioner of the Year by the Kentucky Medical Association in 1962, was widely recognized and respected for his long years of service and his attention to and application of the many advances in medical science. Doctor Walton died September 22, 1964.



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INAUGURATION CEREMONIES were held Sunday, May 16 for the new officers of the Kentucky State Association of Medical Assistants. Mrs. Bettye Fisher, Evansville, Ind., second from left, past president of the American Association, installed the officers. Pictured above are, from left, Miss Dorothy Downs, outgoing president; Mrs. Fisher; Mrs. Wanda Taylor, president; Mrs. Claire Demarest, treasurer; Miss Janet Stead, corresponding secretary; Mrs. Nancy Odekirk, recording secretary; Mrs. Virginia Applegate, vice-president; and Mrs. Tina Gates, president-elect.

Ky. Medical Assistants Assn. Installs New Officers

The Kentucky State Association of Medical Assistants installed as its new president Mrs. Wanda Taylor, Louisville, during its annual meeting May 14-16 at the Kentucky Hotel in Louisville. Mrs. Taylor succeeds Miss Dorothy Downs, also of Louisville, in office.

Mrs. Tina Gates, Louisville, was named president-elect of the Association, to take office in 1966.

Robert C. Long, M.D., a member of the Board of Trustees of the American Medical Association, and Robert G. Cooper, M.D., were among the speakers on the Saturday morning program. Doctor Long presented an analysis of the medicare legislation recently passed by the U.S. House of Representatives. Doctor Cooper spoke on "The Art of Plastic Surgery." Both are from Louisville.

Mr. Jack Ballentine, Louisville attorney, and Mr. James F. Carney, Louisville, vice-president of the J. K. Dennis Company, shared the Saturday program with Doctors Long and Cooper. Homer B. Martin, M.D., Louisville, was the main speaker at the Saturday evening banquet.

Roy H. Moore, Jr., M.D., president of the Jefferson County Medical Society, discussed "Dedication Through Education," at the State Luncheon on Sunday, preceeding the installation of the officers.

Other officers are: Mrs. Virginia Applegate, Louisville, vice-president; Mrs. Nancy Odekirk, Elizabethtown, recording secretary; Mrs. Claire Demarest, Louisville, treasurer; and Miss Janet Stead, Louisville, corresponding secretary.

Dr. Howard Given TB Award

C. C. Howard, M.D., Glasgow surgeon, received the annual loyalty award of the Kentucky Tuberculosis and Respiratory Disease Association during the meeting of the group in Lexington in April. Doctor Howard was recognized for his long service in the fight to eradicate tuberculosis.



Doctor Howard

Except for a brief interval, he has served as chairman of the TB Hospital Commission since it was established in 1940. He was also instrumental in the establishment of the regional TB hospital system now in use. Doctor Howard is chairman of the Kentucky Rural Scholarship Loan Fund, and a former president of KMA.

Henderson KAGP Seminar Set

Five prominent medical guest speakers will present the scientific program at the Kentucky Academy of General Practice's Henderson Seminar June 24 at the First Christian Church, according to Kenneth M. Eblen, M.D., program chairman.

John W. Greene, Jr., M.D., Lexington; Amos Christie, M.D., Nashville; Pat Imes, M.D., Louisville; Frank Brakel, M.D., and John Longstaff, M.D., both of Evansville, will deliver papers at the meeting. Registration will begin at 9:00 a.m. A barbecue and dance at the Henderson Country Club will complete the day's activities.

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James P. Moss, U. of L., Elected National SAMA President

James Paisley Moss of Williamsburg, who will enter his senior year at the University of Louisville School of Medicine this fall, was elected president of the Student American Medical Association at its fifteenth national convention in Chicago April 31-May 6.



Mr. Moss

Moss, who with six others represented the University at the convention, is the first national SAMA president from the school. He is the son of C. A. Moss, M.D., Williamsburg, and received his B.S. degree from the University of Kentucky in 1963.

While attending medical school Moss has served as president of his class during the freshman year, vice-president of the U. of L. SAMA chapter, assistant vice-president of Reigon IV of SAMA, and was, until his election as national president, a vice-president elect of Region IV. He is a member of Phi Chi fraternity.

Also attending the national convention were sophomores Brennan Cassidy, Carl Pfanstiel, and Dick Ramey, and freshmen Ted Buckner, Kent Peterson, and Frank Rickman.

Dr. Fulmer Elected by KTS

Hugh S. Fulmer, M.D., associate professor of community medicine at the University of Kentucky College of Medicine, was chosen president-elect of the Kentucky Thoracic Society at the April 22 KTS meeting in Lexington.

Herbert T. Ransdell, M.D., Louisville, associate professor of thoracic surgery at U. of L., was installed as president at the same meeting, held jointly with the Kentucky Tuberculosis and Respiratory Disease Association. Saul A. Schaffer, M.D., Ashland, was elected secretary-treasurer of the KTS.

National Community Health Week Observance Set Nov. 7-13

The KMA joins with other state medical associations and the AMA in promoting the Third Annual nationwide observance of Community Health Week—November 7-13. "Teaming up for Better Health" will be the theme.

Primary objectives of Community Health Week are to stimulate greater public awareness and appreciation of the wealth of health facilities and services which are available locally and to stress the health progress and medical advances which have been made locally through the concerted effort of all members of the community health team.

The KMA Public Health Committee urges local county medical societies to encourage all local members of health professions and health organizations—public and private—to develop, cooperatively, informative programs which portray the continuing theme of the observance.

Community Health Week has continued to grow in national stature as additional medical societies join with other local health groups in developing a wide variety of commemorative programs and activities of community-wide interest. As we take stock of our present assets, Community Health Week reminds us of our responsibility to make certain that the high standards of health protection and service we enjoy today will be adequate for the needs that will arise in future years.

U. Of K. Medical School States New Policy on Externships

The members of the KMA Council on Medical Education and Hospitals have requested publication of the following policy adopted by the University of Kentucky College of Medicine, which requires students to obtain permission before engaging in any clinical activities outside the college.

"It is the policy of the College of Medicine to be concerned with all of the clinical experiences that students have with patients during the period in which they are enrolled as students in good standing. This applies not only to experience obtained as a regular part of the curriculum of the College of Medicine, but also to experience that may be obtained in externships or other clinical activities during vacation periods or free time. The concern relates not only to the educational value of such experience but also the ethical and legal implications of such clinical experience.

"Therefore it is a policy of the College of Medicine and a requirement for maintaining good standing in the College that all students obtain appropriate approval from the office of Student Services before accepting positions as externs, physicians' helpers, or other employment which involves work with patients, whether or not the students are paid for their work.

"When the circumstances appear appropriate, permission will be given in writing. In granting permission, attention will be given to the character of supervision which will be provided for students in recognition of the educational implications of such experience and the fact that the student is not a licensed physician. Special attention will be given to the level of responsibility which the student is expected to discharge.

"Failure to secure such permission will be deemed sufficient cause for disciplinary action."

PM&R Academy to Meet Aug. 22-27

The American Academy of Physical Medicine and Rehabilitation will hold its 1965 annual meeting August 22-27 at the Sheraton Hotel in Philadelphia. The meeting will consist of formal lectures and educational seminars in Hypertonia, Hypotonia and Forensic Physiatry (Workmen's Compensation).



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Vitamin B_6 (pyridoxine hydrochloride)		1 mg.
Nicotinamide	(5 MDR*)	50 mg.
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Inositol†		100 mg.
Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
Cobalt (as chloride)		1 mg.
Manganese (as sulfate)		1 mg.
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SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their fall and winter meetings. At the same time they are choosing the topics to be discused, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in The Journal. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Kentucky 40205.

IN KENTUCKY

JUNE

10 KAGP Harrodsburg Seminar, Beaumont Inn, Harrodsburg

24 KAGP Henderson Seminar, First Christian Church, Henderson

JULY

21-22 KAGP Big Sandy Seminar, Jenny Wiley State Park, Prestonsburg

AUGUST

5 KAGP Bardstown Seminar, Bardstown High School, Bardstown

21-22 KAGP Bluegrass Seminar, Imperial House, Lexington

SEPTEMBER

21-23 KMA ANNUAL MEETING, Convention Center, Louisville

OCTOBER

7 KAGP Maysville Seminar, Mason County Health Department, Maysville

IN SURROUNDING STATES

JUNE

12-13 American Association of Neuropathologists, Hotel Dennis, Atlantic City, New Jersey

14-15 American Geriatrics Society, Inc., Roosevelt Hotel, New York

14-16 American Proctologic Society, Hotel Leamington, Minneapolis

14-16 American Neurological Association, Claridge Hotel, Atlantic City, New Jersey

14-18 American College of Physicians, Postgraduate Course No. 18, Psychiatry for the Internist, RESCHEDULED FOR NOVEMBER 1-5, University of Colorado Medical Center, Denver

14-18 American College of Physicians, Postgraduate Course No. 19, Hematology for Internists, in the Light of Recent Development, University of Rochester School of Medicine, Rochester, New York

15-19 American Medical Women's Association, Philadelphia

17-19 Endocrine Society, Americana Hotel, New York

17-20 American College of Chest Physicians, Waldorf-Astoria Hotel, New York

19 Academy of Tuberculosis Physicians, Henry Hudson Hotel, New York.

19-20 American College of Legal Medicine, Belmont Plaza Hotel, New York

20-24 AMERICAN MEDICAL ASSOCIATION, Americana Hotel, New York

27-29 International Congress on Smoking and Health (First), New York

28-July 1 American Orthopaedic Association, Homestead Hotel, Hot Springs, Virginia

JULY

26-30 "Interpretation and Therapy of Cardiac Arrhythmias," Cardiovascular Institute, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania

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Contraindications: (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms.

Side Effects: Mild effects, such as skin rashes, diarrhea, nausea and vomiting have occasionally appeared.

Precautions: As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

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References: 1. Editorial. Brit. M. J. *ii*:223 (July 22) 1961. 2. Rolinson, G. N., and Stevens, S.: Brit. M. J. *ii*:191 (July 22) 1961. 3. Stewart, G. T., *et al.:* Brit. M. J. *ii*:200 (July 22) 1961. 4. Brown, D. M., and Acred, P.: Brit. M. J. *ii*:197 (July 22) 1961. 5. Batchelor, F. R., *et al.:* Nature *183*:257, 1959. 6. Knudsen, E. T., *et al.:* Brit. M. J. *ii*:198 (July 22) 1961. 7. Doyle, F. P., *et al.:* Nature *191*:1091 (Sept. 9) 1961. 8. Acred, P., *et al.:* Brit. J. Pharmacol. *18*:356, 1962. 9. Harrison, P. M., and Stewart, G. T.: Brit. J. Pharmacol. *17*:420, 1961. 10. Editorial. Lancet *ii*:723 (Oct. 5) 1963.

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Ky. M.D. Gets AMA-ERF Grant For Tobacco-Smoke Study

William H. Anderson, M.D., associate professor of medicine and chief of the section on pulmonary diseases at the University of Louisville School of Medicine, is among 15 recipients of new tobacco research grants recently awarded by the American Medical Association Education and Research Foundation's Committee on Tobacco and Health.

Doctor Anderson will receive $6,357 to evaluate a new technique to study the acute histological effects of tobacco smoke on rabbit lungs.

The 15 grants bring to 43 the number of tobacco research projects the AMA-ERF is currently giving financial support. The grants are a part of a long-range study program on tobacco and health authorized in 1963 by the AMA House of Delegates.

U. of L. Students Recognized At Honors Day Program

Jerry B. Buchanan, Charleston, S.C., received the annual Omicron Delta Kappa award as the outstanding male graduating senior at the annual U. of L. Medical School Honors Day Convocation at the Medical Arts Building in Louisvile May 6. Buchanan is president of the U. of L. chapter of the Student American Medical Association.

Dean Donn L. Smith, M.D., presented the Dean's Award for Excellence to J. David McNeeley, senior from Frankfort, and Stephen A. Blackman, West Lake, Ohio, president of the senior class, won the Louisville Pediatric Society Award. Fourteen students from the junior and senior classes, including Buchanan and Blackman, were elected to Alpha Omicron Alpha, national medical honorary.

Twenty-six men, representing all four medical school classes, received honors and awards at the program, which featured the annual AOA lecture by Robert J. Glaser, M.D., dean of the Stanford University School of Medicine.

Seventeen Physicians Are Added To KMA Membership Roster

The records of the KMA membership department show the addition of seventeen new members as of May 5. The following names have been added to the roster:

Robert T. Johnson, M.D., and James M. Lee, M.D., Beaver Dam; Clifton D. Lamm, M.D., Smiths Grove; William M. McCormack, M.D. and Jerry W. Martin, M.D., both of Bowling Green, and Thomas E. Lester, M.D., Lynch.

New members from Louisville are Lila H. Carter, M.D.; Robert J. Kaiser, M.D.; James A. Meyers, M.D.; Kareem Minhas, M.D.; Robert G. Overstreet, M.D.; and Arthur F. White, M.D.

New members practicing in Lexington are: Peter H. Jones, M.D.; Dean H. Morrow, M.D.; Bernard L. Peterson, M.D.; and John W. Roddick, Jr., M.D.

NEWS ITEMS

George S. Beard, M.D., Hartford surgeon, recently received the "Outstanding Young Man" award, presented annually by the Hartford Junior Chamber of Commerce. Doctor Beard, a 1956 graduate of the University of Louisville School of Medicine, has practiced in Hartford for a little more than a year.

W. M. Savage, M.D., has announced the re-opening of his office in Maysville for the practice of general surgery. Doctor Savage practiced in Maysville prior to 1961, at which time he moved to Tennessee.

C. E. Crabtree, M.D., has closed his office in Buffalo, where he was in general practice, it has been announced. Doctor Crabtree will be taking additional postgradua'e training.

Carl F. Essig, M.D., a neurologist, has joined the staff of the U. S. Public Health Service Hospital at Lexington, it was recently announced. Doctor Essig, who has served for 16 years with the Public Health Service, graduated in 1947 from Western Reserve School of Medicine, Cleveland, and interned at Watts Hospital, Durham, N.C.

Alexander V. McBee, M.D., is a new member of the staff of the division of ophthalmology at the University of Kentucky Medical Center. A graduate of Tulane University School of Medicine, he was in private practice before coming to Lexington. Doctor McBee completed both his internship and residency training at Charity Hospital, New Orleans.

The Hardin County Medical Society was recognized by the Kentucky Public Health Association as the group having made the most significant contribution to public health in Kentucky in 1964. David T. Lewis, M.D., Elizabethtown, accepted the award on behalf of the Society at the KPHA's annual meeting in Lexington late in April.

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Return of Postgraduate Money To General Fund Approved

The KMA Board of Trustees recently approved the recommendation of the Council on Medical Education and Hospitals that the funds in the Postgraduate Medical Education Fund be returned to the KMA General Fund Account.

In making the recommendation, the Council members pointed out that the functions currently being performed in the Postgraduate Office could be maintained in the KMA Office since the duties of this office consist primarily of keeping records of scheduled meetings and publishing postgraduate opportunities in The Journal of KMA.

The tax-exempt status of the postgraduate fund is to be maintained and the Council will ask for funds in the future should the need arise.

Ky. TB & RD Assn. Elects

E. N. Maxwell, M.D., Louisvile radiologist, was elected president of the Kentucky Tuberculosis and Respiratory Disease Association during the joint meeting of the Association and the Kentucky Thoracic Society April 22-24 in Lexington. Doctor Maxwell is an assistant clinical professor of radiology at the University of Louisville School of Medicine.

The Physician's Contribution

(Continued from Page 423)

eradication of disease is the important task of helping each individual develop his creative and productive capacity to contribute more to the groups of which he is a member than he demands from those groups. And we know that when we talk of emotional wellness we must concern ourselves not only with individual well-being, but with the health of society. And we know that no society, no group can be strong and well, whether family or nation, which ignores the essential element of individual responsibility.

Let us here then, each in his own appropriate way, rededicate ourselves to making our best possible contribution to the emotional wellness of all of us.

Catalog of Services Available

The 1965 edition of the "SK&F Catalog of Services" is now available to KMA members, it has been announced. The catalog describes clinically oriented post-graduate medical films, booklets, speakers bureau, and medical color TV. To obtain a copy of the catalog, write to Smith Kline and French Laboratories, Services Department, 1500 Spring Garden St., Philadelphia, Pa., 19101.

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*Dorhout Mees,E.J.,and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

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KMA Council and Committee Reports

Council on Medical Education and Hospitals

George A. Sehlinger, M.D., Louisville, Chairman

KMA Headquarters Office **Thursday, May 13, 1965**

The KMA Council on Medical Education and Hospitals met for its second time this Associational year on May 13.

The members of the Council reviewed the final reports of the five Committees serving under the Council and took appropriate action prior to forwarding the reports to the KMA House of Delegates. Another major matter discussed by the Council members was a thorough review of the report on the questionnaire on Medical Education which was distributed to all physicians in Kentucky in June, 1964.

The Council members also reviewed nominations for the 1965 KMA Faculty Scientific Achievement Award and selected the recipients of the award for the 1965 KMA Annual Meeting.

Advisory Committees to UL-UK

George A. Sehlinger, M.D., Louisville, Chairman—UL; Andrew M. Moore, M.D., Lexington, Chairman—UK

KMA Headquarters Office **Thursday, April 22, 1965**

The Advisory Committees to the University of Louisville School of Medicine and the University of Kentucky College of Medicine met jointly during this Associational year, and concentrated attention on the medical questionnaire developed by the Council on Medical Education and Hospitals to study and improve "Town and Gown " relationships.

The questionnaire was sent to the state's approximately 2,700 physicians and replies were elicited from 720 (27%). It was designed to elicit basic identifying information about the physician's own medical education; the location and type of his practice; his current affiliation with a medical school; his familiarity with and opinions concerning medical educators and research; his current use, potential future use, familiarity with and opinions concerning postgraduate education; and his opinions concerning relationships between medical school faculty members and practicing physicians.

Following a very thorough review of this report, it was noted that four basic categories received the most comment from those replying: (1) communication; (2) postgraduate education; (3) research; and (4) general practice. These subjects will be discussed in more detail in the committees' final report to the 1965 Session of the KMA House of Delegates.

General Practice Committee

E. C. Seeley, M.D., London, Chairman

Kentucky Hotel, Louisville **Thursday, May 6, 1965**

The KMA General Practice Committee met recently at the Kentucky Hotel in Louisville and discussed in great length the shortage of general practitioners in this country and in Kentucky in particular. It was noted that currently only 25% of all the physicians in America are now engaged in general practice, and this group provides approximately 65% of the care in general practice-type illnesses, which constitute 85% of all physician-patient contacts outside the hospital.

Following a discussion, the committee recommended that KMA go on record in favor of influencing the medical schools in Kentucky to establish departments of General Practice or Family Practice, and utilizing all available means to accomplish this aim.

The committee held considerable discussion on the need of statistical information concerning the distribution of physicians in Kentucky as to type of practice. It was recommended that a survey be made of all physicians in the state to determine their type of practice whether it be general practice or a specialty.

Aging Committee

Earl P. Oliver, M.D., Scottsville, Chairman

KMA Headquarters Office **Tuesday, April 20, 1965**

Members of the Aging Committee met at the KMA Headquarters Office on April 20 to prepare its final report to the 1965 House of Delegates.

The members were briefed on the Kentucky Commission on Aging on which two KMA physicians are members, and the view was expressed that the medical profession should continue to be represented on this group. The chairman reported on the recently held AMA Conference on Aging and Long-term Care in Chicago, and said much discussion was held on discouraging the practice of retirement for the aged citizen due to age alone.

The committee discussed the accreditation of nursing homes and future medical care programs and made several recommendations to be included in the committee's final report to the House of Delegates.

Dental-Nurse-Pharmacy Committee

Melvin J. Weber, M.D., Ludlow, Chairman

KMA Headquarters Office **Thursday, April 29, 1965**

A joint meeting of physicians and pharmacists took place at KMA Headquarters recently and members discussed mutual problems of their respective groups.

The chairman stated that the AMA held a Conference on Medicine and Pharmacy last year and its results prompted an urging from the AMA that a similar meeting take place on the state level so that the two groups could talk over problems of concern and perhaps set up a joint Code of Ethics.

Following a thorough discussion of many items, recommendations were made for exploration of possible solutions in those areas of concern to both the physician and pharmacist.

Blood Banks Committee

Ellis Fuller, M.D., Louisville, Chairman

KMA Headquarters Office **Thursday, May 13, 1965**

The KMA Blood Banks Committee met recently and opened their discussion by reviewing the purpose and duties of the committee.

In determining the future course of activity, the committee members advised a survey of the facilities in Kentucky that transfuse blood, and had a discussion about various types of blood bank facilities, proper supervision of blood banking and referred to legislation of other states pertaining to blood and blood banking activities.

Members of the committee recommended that a letter be sent to county society secretaries urging the establishment of blood bank committees, if one is not already part of the society, and also recommended that a series of articles on blood and blood banking activities, be written by persons very knowledgeable in this area for publication in a future issue of the KMA Journal and the Nursing Journal.

Committee members discussed in great detail the AMA policy on blood banks and recommended several changes which the committee felt would strengthen the KMA implementation of the policy.

Case Discussion

(Continued from Page 427)

myeloma was entertained. After this study the patient suffered increasing oliguria and uremia, expiring eight days later. This complication of intravenous urography in the presence of multiple myeloma is discussed relative to its pathogenesis. A warning is sounded to avoid intravenous urograms in patients who may have this disease, particularly in its occult form where the diagnosis is obscure.

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4. Perillie, P. E., and Conn, H. O. *Acute renal failure after intravenous pyelography in plasma cell myeloma.* J.A.M.A., 167, 2186-2189, 1958.
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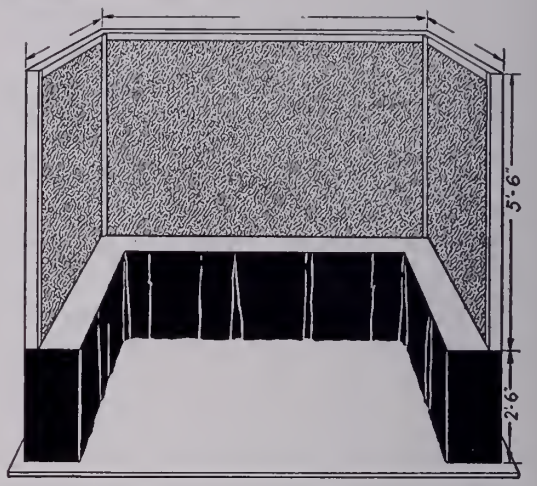
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3. Do you have a built-in exhibit?
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)

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 Back wall Side walls (All side walls are 4')

 Square feet needed? Shelf desired? (yes or no)
7. Indicate sources of assistance provided in connection with the exhibit.
8. Has this exhibit been exhibited before? If so, when & where?

Date

Signature of Applicant

The Kentucky Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

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COUNTY SOCIETY REPORTS

Boyle

Louis J. Beto, M.D., took office March 1 as president of the Boyle County Medical Society, according to the recent secretary's report received in the KMA office. Doctor Beto will be assisted in his official duties by the following officers: Stuart P. Hemphill, M.D., vice-president; Chris S. Jackson, Jr., M.D., secretary-treasurer; Chris S. Jackson, Sr., M.D., KMA delegate; and Charles W. Sisk, M.D., alternate delegate. All are from Danville.

Green

The new president of the Green County Medical Society is Robert L. Shuffett, M.D., it was announced recently. J. M. Dishman, M.D., will serve as secretary of the group, and Kenneth J. S. DeSimone, M.D., will be the delegate to KMA, with George S. Cheatham, M.D., serving as alternate. All the officers are from Greensburg.

Lawrence

Arthur B. Richards, M.D., wil serve as president of the Lawrence County Medical Society for the coming year, it has been reported. Doctor Richards will be assisted by the following officers: Roy L. Clemons, M.D., vice-president, and George P. Carter, M.D., secretary. Doctor Richards will be the KMA delegate. An alternate delegate has not been named. All are from Louisa.

Logan

C. H. Mathis, M.D., was elected president of the Logan County Medical Society for 1965, it has been reported. Other officers serving this year will be D. E. Wood, M.D., vice-president; W. T. Hill, M.D., delegate to KMA. Doctor Mathis will serve as alternate delegate. All are from Russellville.

McCracken

A special meeting of the McCracken County Medical Society was called to order at 7:10 p.m. April 16, by the president, Joe B. Spaulding, M.D., at the McCracken County Health Department.

The meeting was called for the purpose of discussion a Local Indigent Medical Care program under the Economic Security Act or under the Anti-Poverty Bill. Twenty-three members were present, as well as Mr. Ralph Watson, director of the Paducah and McCracken County Development Committee, and his assistant, Mr. Robert Shell.

Doctor Spaulding turned the program over to H. G. Sargent, M.D., who pointed out that any program devised would have to have the full support of the McCracken County Medical Society, and would actually have to be directed by it. He indicated that there was considerable Federal money available to underwrite such a program for the care of local indigent patients.

At the present time about $150,000 is available before the end of this fiscal year. Following that, almost two million dollars could be made available should a local program be acceptable to the authorities in the state capitol as well as the national capitol. Many discussants argued the pros and cons of this proposed program. Political debate as well as medical debate ensued. Almost all agreed that some local indigent patients do not receive adequate care under either the county or city programs.

At the conclusion of the debate, a motion was made by William W. Myre, M.D., and seconded by J. Vernon Pace, M.D., as follows:

> That the Society would pursue this matter further and would authorize Doctor Sargent and Mr. Watson to go to Frankfort and subsequently to Washington, D.C., in an effort to see what type of program would be acceptable to the political powers-that-be, so that the Society can proceed further in trying to organize and establish such a plan for the care of Locally Indigent Patients under the auspices of the Economic Security Act, and the Anti-Poverty Program.

The motion was also in favor of a physician being hired outright to direct the program and refer patients to local physicians as he saw fit.

There being no further business, the meeting adjourned at 8:45 p.m.

McCracken

The regular meeting of the McCracken County Medical Society was held on April 28 at the Paducah Country Club.

Following an excellent dinner and social hour, Robert Siegel, M.D., of the University of Kentucky, gave a comprehensive discussion of the clinical and patho-physiologic manifestations of hypertension. He also discussed to some length the remedial lesions which produce hypertension. A brief question and answer period followed his presentation.

President J. B. Spaulding, M.D., called the business meeting to order for a short session, which adjourned at 10:05.

Ohio

Charles Price, M.D., Hartford, was named president of the Ohio County Medical Society for 1965. George S. Beard, M.D., Hartford, was elected vice-president and president-elect. Robert T. Johnson, M.D., Beaver Dam, will serve as secretary-treasurer. Doctor Beard will also serve as delegate to the KMA, and Oscar Allen, M.D., Beaver Dam, will be the County's alternate delegate.



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The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools.

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

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These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when other potent chemotherapeutic agents are given concurrently because of the increased possibility of toxic reactions; when the patient cannot be seen regularly; when the patient is senile.

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In Memoriam

SHELTON H. MANN, SR., M.D.
Louisville, Ky.
1909-1965

Shelton H. Mann, Sr., M.D., 56, Louisville anesthesiologist, died March 30 following a long illness. Doctor Mann, a past president of the staff and former chief of anesthesiology at Jewish Hospital, was a 1933 graduate of the University of Louisville School of Medicine. He was a member of a number of state, local and national medical organizations.

AULTMAN BAXTER SHELTON, M.D.
Manchester, Ky.
1901-1965

A. B. Shelton, M.D., 63, Manchester, died April 7 at a West Union hospital where he had been a patient for four days. Doctor Shelton, who had practiced general medicine in Cincinnati for 31 years before returning to Clay County in 1959, graduated in 1926 from the Eclectic Medical College of Cincinnati.

WILLIAM EDWARD DEAN, M.D.
Covington, Ky.
1894-1965

William E. Dean, M.D., a general practitioner in Kenton County for many years, died Monday, April 19, at the age of 70. Doctor Dean, a 1923 graduate of the Eclectic Medical College of Cincinnati, had served as a staff physician at Rosedale Manor in Kenton County for several years.

MARVIN CHESTER PENTZ, M.D.
Nicholasville, Ky.
1882-1965

Marvin C. Pentz, M.D., 83, Jessamine County general practitioner and an emeritus member of the Kentucky Medical Association, died April 28 at a Lexington hospital following a short illness. Doctor Pentz, of Nicholasvile, had practiced in the county for 35 years before his retirement in 1963. He was a 1905 graduate of the St. Louis College of Physicians and Surgeons.

JAMES BALLINGER TARTER, M.D.
Russell Springs, Ky.
1882-1965

James B. Tarter, M.D., who had practiced general medicine in Russell County for more than 55 years, died suddenly May 4 at his home following a heart attack. Doctor Tarter, 82, graduated from the Medical Department of the University of Louisville in 1910, and went to Russell County, where he had maintained his practice until his death.

CHRISTOPHER A. THOMPSON, M.D.
South Shore, Ky.
1880-1965

C. A. Thompson, M.D., 85, Greenup County general practitioner, died May 7 at a Portsmouth hospital following a month-long illness. Doctor Thompson, a native of Iowa, received his medical degree from Northwestern University School of Medicine in 1908. He had lived at South Shore for the past 15 years, though he had retired from active practice several years ago.

WILLIAM WARDER SHEPHERD, M.D.
Campbellsville, Ky.
1919 - 1965

William W. Shepherd, M.D., Taylor County Coroner for 15 years and a past president of the National Association of Coroners, died May 16 of a heart attack. He was 46. Doctor Shepherd, a general practitioner and a 1946 graduate of the University of Louisville School of Medicine, had served as executive secretary of the Coroners Association of Kentucky since its organization in 1950. He was active in community, church, political and civic affairs.

A Case of Sporotrichosis

(Continued from Page 416)

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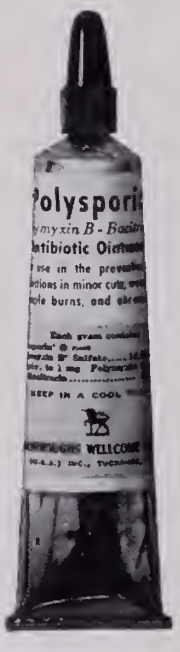
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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #4-63. This patient is 41 years old, married, white, gr 8 para 7. No prenatal care had been given. Three pregnancies were delivered by midwives at home. She was seen February 18, 1963, in the hospital emergency room, appearing acutely ill, with intermittent uterine contractions and vaginal bleeding. BP 110/70, P. 96, T. 100, R. 22. The uterus was enlarged to the umbilicus and soft. The cervix on vaginal examination was 1 cm. dilated; there was bright blood oozing from the internal cervical os; no presenting part was palpable. Fetal heart tones were heard in the left lower quadrant at 140-150 per minute. Diagnosis was uterine pregnancy, approximately 30 weeks gestation, premature labor and iron deficiency anemia. Her hemoglobin was 9.0 grams, hematocrit 32%, WBC 17,500. Five hundred ml. whole blood was given. She was started on antibiotics when it was determined her membranes had ruptured. Hemoglobin 12 hours after the transfusion was 10.6 grams, hematocrit 36%.

On the second hospital day, temperature was 101.8 F. Antipyretics were given. Irregular contractions ensued with a continuous seepage of amniotic fluid and minimal vaginal bleeding. The fetal heart rate remained constant at 140 to 150 in the left lower quadrant. X-ray revealed a single fetus probably in the early third trimester with the vertex in the pelvis. The patient passed large clots. On February 23, 1963, hemoglobin was 9.5 gm., hematocrit 32% and a second 500 cc. whole blood was given. Hb was 11 gm. the following morning. She was afebrile the third hospital day and remained so the rest of her hospital course.

On February 26, 1963, Hb was 12 gm., hematocrit 37%. No active contractions occurred for 24 hours. The fetal heart was good. The patient was dismissed to bed rest at home. The antibiotics were continued. She was instructed to return if she had any chills, fever or vaginal bleeding. She returned to the hospital February 28, 1963, at 3:30 a.m., having contractions every three minutes lasting 35 seconds. Temperature was 102.4, P 100, R 22. A few small clots were passed vaginally. The cervix was 3-4 cm. dilated, 80-90% effaced with a cephalic presentation. Fetal heart tones could not be heard. Antibiotics and analgesics were given. Hemoglobin was 11 gm., hematocrit 37%. One thousand ml. D5w with 1 gram of Chloromycetin and 10 units of Pitocin was started IV at 8:45 a.m. She also received 2 cc. Combiotic IM at 9:30 a.m. Temperature at noon was 100.2, P 90. Fetal heart tones were not heard. She complained of severe pain and chills. She delivered spontaneously in bed a premature stillborn female at 3:10 p.m. The placenta failed to deliver and was manually removed. There was approximately 150 to 250 cc. bleeding. Blood pressure immediately post partum was 90/60, P 96. She appeared very toxic and was given 500 cc. whole blood. Blood pressure was 50/? at 3:35 p.m. 1000 cc. D5w with 2 cc. Aramine was started IV. The IV infiltrated. At 6:10 p.m. nasal oxygen was given because of cyanosis. She continued a downhill course and expired at 7:30 p.m. Autopsy was obtained. The uterus was opened, there were no lacerations but a portion of the placenta approximately 6-8 cm. in diameter was retained plus approximately 750-1000 cc. of dark clotted blood. The lungs both appeared grossly normal, well aerated, there was no apparent embolus.

Comment

It was the opinion that the patient died of post partum infection. The focus of infection being the necrotic placenta. There was a large thrombus in the peripheral sinus of the placenta.

In the opinion of the committee this was a direct obstetric death with preventable factors. She should not have been discharged after her first admission. In general, it is advisable to continue hospitalization for any patient with ruptured membranes until she is delivered, especially in this socio-economic group. This would be essential for a patient that has shown a septic course. In such cases it is advisable to deliver the patient as soon as possible if there is any suspicion that the site of infection is the uterus. It is well established that antibiotics do not enter the products of conception at levels to be therapeutically effective.

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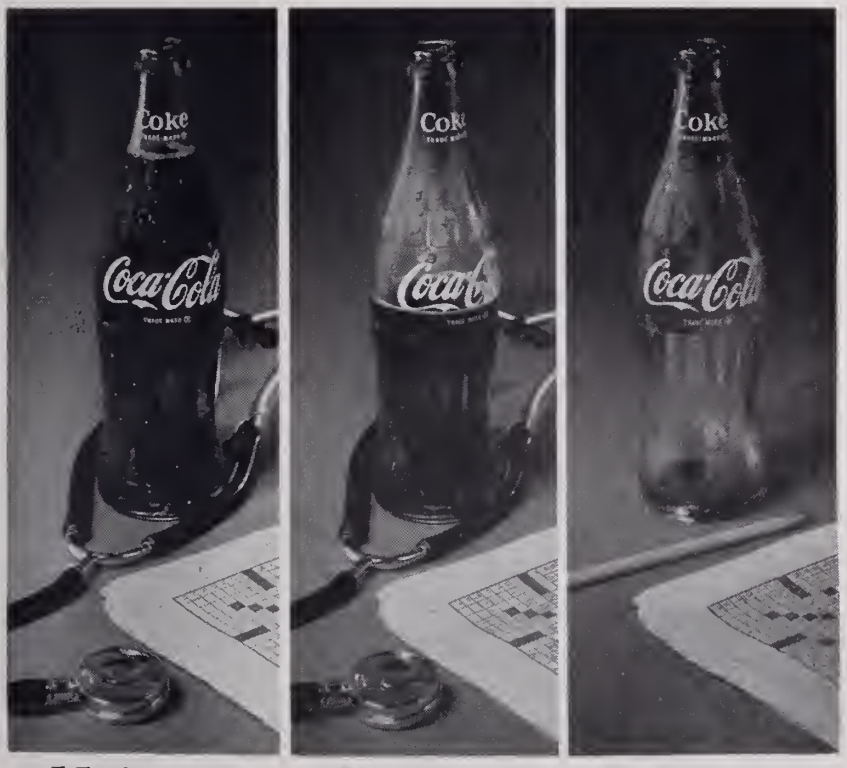
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The many unanswered questions as to the interpretation and implementation of the final bill will take many months to answer. One of the most important of these is what happens to the doctor-patient relationship as we know it today with the intervention of the federal government as the third party.

And finally, when we get all the answers to these questions, can I honestly advise my teen-age son to continue his plans to become a Doctor of Medicine?

KENNETH M. EBLEN, M.D.
VICE-PRESIDENT (WESTERN)

†This is the last in a series of four guest articles written for this page at the invitation of the KMA president by the president of the Women's Auxiliary and the three KMA vice-presidents.



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for relaxing stress-induced
smooth muscle spasm

...nothing, that is, except the
sedative-antispasmodic action of

Donnatal®

Prescribed by more physicians than any other antispasmodic —*well over 5 billion doses!*

*This one at Navajo Loop Trail, Bryce Canyon National Park, Utah

By its combination of natural belladonna alkaloids with phenobarbital, DONNATAL provides potentiated antispasmodic action unsurpassed in its record of dependable efficacy and safety.

Contraindications: Glaucoma, advanced renal or hepatic disease, or hypersensitivity to any ingredient. *Precautions:* Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction as in prostatic hypertrophy. *Side Effects:* Blurred vision, difficult urination, or flushing and dryness of the skin may occur at higher dosage levels, rarely at the usual dosage.

In each Tablet, Capsule or 5 cc. Elixir		In each Extentab®
0.1037 mg.	hyoscyamine sulfate	0.3111 mg.
0.0194 mg.	atropine sulfate	0.0582 mg.
0.0065 mg.	hyoscine hydrobromide	0.0195 mg.
16.2 mg. (¼ gr.)	phenobarbital (¾ gr.)	48.6 mg.

(Warning: may be habit forming.)

A. H. ROBINS CO., INC., RICHMOND 20, VA.


for the
patient with
'pain &
spasm'

to assure pain relief in relaxant therapy

In painful skeletal muscle spasm, relief of pain does not always follow relaxant therapy, as in the presence of—

Provocative pain, when muscle spasm is triggered by some underlying musculoskeletal defect.

Residual pain, when relaxation of severe spasticity leaves a degree of myalgia that continues to cause discomfort.

Severe pain, when the degree of pain is such as to cause persistence of symptoms in spite of relaxant therapy.

Emotionally aggravated pain, when anxiety or agitation creates tensions that undermine the efficacy of relaxant medication.

For decisive relief—lest persistent pain overshadow the benefits of relaxant therapy—many physicians prescribe ROBAXISAL or ROBAXISAL-PH.

Synergistic double action

In ROBAXISAL the potent action of the well-recognized skeletal muscle relaxant Robaxin (methocarbamol)[1,2,3,4,5,6,8] is accompanied by the time-tested analgesia of aspirin. This "rational therapeutic combination"[7] proves especially effective, since clinical studies have attested that the concurrent ingestion of methocarbamol and aspirin produces higher salicylate levels than equivalent doses of aspirin alone[7]...with "gratifying relief" of pain as well as spasm.[7]

INDICATIONS: Strains and sprains, painful disorders of the back, "whiplash" injury, myositis, pain and spasm associated with arthritis, torticollis, and headache associated with muscular tension.

CONTRAINDICATIONS: Hypersensitivity to any one of the components.

SIDE EFFECTS: Lightheadedness, slight drowsiness, dizziness and nausea may occur rarely in patients with unusual sensitivity to drugs, but usually disappear on reduction of dosage.

Supplementary sedation

In ROBAXISAL-PH, the relaxant Robaxin is combined with the analgesic-sedative ingredients of the popular Phenaphen formula, for use when emotional tensions aggravate the spasm-pain syndrome. Anxiety is eased by the phenobarbital component, which also enhances analgesic effects; and any tendency to gastric upset is minimized by hyoscyamine in the formulation.

References: 1. Carpenter, E. B., South. M.J. 51:627, 1958. 2. Crookshank, J. W.: J. Louisiana State Med. Soc. 114:272, 1962. 3. Feinberg, I., et al.: Am. J. Orthoped. 4:280, 1962. 4. Fitzgerald, W. J.: Miss. Valley M.J. 82:146, 1960. 5. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 6. Meyers, G. B., and Urbach, J. R.: Penna. M.J. 64:876, 1961. 7. Truitt, E. B., Jr., Morgan, A. M., and Nachman, H. M.: South. M.J. 54:318, 1961. 8. Weiss, M., and Weiss, S.: J. Am. Osteopath. Assn. 62:142, 1962.

ROBAXISAL®

Robins

Each pink-and-white laminated Tablet contains:

Robaxin® (methocarbamol, Robins).....400 mg.

U. S. Pat. No. 2770649

Aspirin (5 gr.).....325 mg.

ROBAXISAL®-PH

Each green-and-white laminated Tablet contains:

Robaxin® (methocarbamol, Robins).....400 mg.

Phenacetin (1½ gr.).....97 mg.

Aspirin (1¼ gr.).....81 mg.

Hyoscyamine sulfate.....0.016 mg.

Phenobarbital (⅛ gr.).....8.1 mg.

(Warning: May be habit forming.)

A. H. ROBINS CO., INC., Richmond 20, Virginia



Answer to Questions About Your Blue Shield

Q. How many Blue Shield members are now protected under Schedules C & D (PSI)?

A. *As of August 1, 1964, there were 129,480 members protected under Schedules C & D.*

Q. When I retire and start paying my Blue Shield on a direct basis instead of through a group, how much will it cost?

A. *The quarterly cost if you have Schedule C is $4.80 single and $12.45 family; Schedule D, the cost is $6.30 single and $17.40 family.*

Q. On the average, how many Blue Shield claims do you handle every day?

A. *1,300 a day average.*

Q. If patient suffered acute respiratory obstruction requiring intra-trachial intubation and resusitation, would there be any allowance to the anesthesiologist for this?

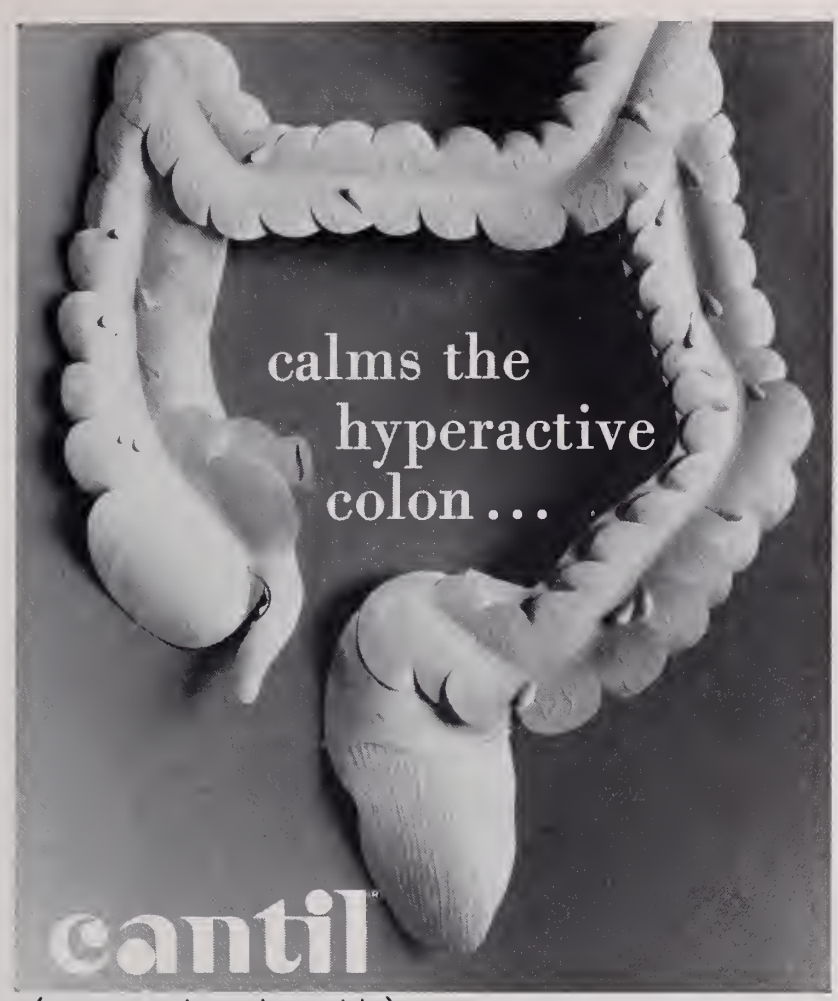
A. *Some claims are referred to the Blue Shield Medical Advisory Committee, composed of doctors, for their consideration. Any allowance would be determined by this group, based on their report of services rendered.*

Q. How may a subscriber apply for nursing home care under the Extended Benefits program?

A. *To receive benefits for care provided in an approved convalescent hospital or approved nursing home, the member must present itemized bills showing (1) Name of Patient, (2) Date of admission, (3) Period covered by bills, (4) Per diem charge, (5) Total charges along with Extended Benefits Claim Form signed by the attending physician.*

Q. What basic diagnostic procedures are excluded under the Standard and Preferred contracts? Does this also apply to the new Blue Shield programs C and D?

A. *The Standard and Preferred Blue Shield contracts, as well as Schedule C & D exclude all diagnostic procedures except those listed in the certificate of membership which are, bronchoscopy and cystoscopicexam. To include diagnostic procedures would make the cost of protection beyond the means of most members.*



(mepenzolate bromide)

helps restore normal motility and tone

Cantil (mepenzolate bromide) works in the colon. In irritable colon, spastic colon, ulcerative colitis and other functional and organic colonic disorders, it acts to:

- control diarrhea/constipation
- relieve spasm, cramping, bloating
- make patients more comfortable

with little effect on stomach, bladder or other viscera.

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250.

CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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Milwaukee, Wisconsin 53201

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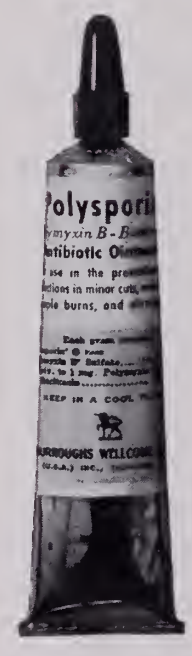
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broad-spectrum antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **Contraindication:** This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.
Supplied: In ½ oz. and 1 oz. tubes
Complete literature available on request from Professional Services Dept. PML.

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more complete relief for the "dyspeptic"

DACTILASE®

Dactilase provides comprehensive therapy for a wide range of digestive disorders. Its antispasmodic and anesthetic actions rapidly relieve pain and spasm. Dactilase decreases hypermotility without inducing stasis. In addition, it supplies digestive enzymes to help reduce bloating, belching and flatulence. Dactilase does not interfere with normal digestive secretions. Very often it can be a most useful answer to the dyspeptic's needs.

DACTILASE: Each tablet contains: Dactil® (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylolytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201



TRAUMA TO THE LIVER: By Gordon F. Madding, M.D., and Paul Kennedy, M.D.; published by W. B. Saunders Company, Philadelphia, 1965; 134 Pages; Price, $6.00.

This concise, well-written monograph is quite timely when vehicular accidents and injuries of violence are on the rise. The authors have succeeded in enriching each chapter with material of their own and with cited experiences and investigations of others interested in liver injury and allied topics.

The chapter on surgical anatomy and the illustration of the segmental division of the liver based on intrahepatic vascular distribution is excellent. It can be of especial help to the surgeon who infrequently deals with lesions of the liver and who is apt to erroneously follow the surface markings as guides for subdivision of the liver into lobes and segments.

The chapter on diagnosis points clearly to the unreliability of physical signs and symptoms and to the lack of any specific laboratory test for detection of liver injury and assessment of its extent. The authors have rightly emphasized the merit of a high index of suspicion and the value of celiotomy and thoracotomy for exploration of the liver.

In the chapters on the management of liver wounds their admonition against packing and suturing of lacerated edges, entrapping devitalized tissue and hematomas, is well justified. The importance of judicious excision of devitalized tissue, even to the extent of partial or complete lobectomy, and of adequate drainage is well documented. Prophylactic use of appropriate antibiotics and biliary decompression appears to be justified. Their suggestions for utilizing temporary afferent vascular occlusion to control excessive bleeding, and for mild hypothermia to add safety when confronted with severe liver injury, are worthy of serious consideration.

One may differ with the authors regarding certain aspects of the management of shock. Contrary to their practice, frequent use of central venous pressure monitoring and liberal administration of balanced salt solution in addition to blood and glucose are to be recommended. Low molecular weight dextran is to be used not for replacement of volume deficiency but for improving microcirculatory flow in addition to other appropriate fluid therapy. The use of veins of the lower extremities for fluid and blood administration is to be discouraged. This practice may lead to the potential hazards of thrombophlebitis and escape of the administered blood and fluid when the iliac vein or the inferior vena cava is concomitantly lacerated with pelvic and abdominal injuries.

Doctors Madding and Kennedy are to be complimented for presenting the important subject of trauma to the liver in a comprehensive form and a readable style which will benefit all students of trauma and those involved in the care of the afflicted.

M. Atik, M.D.

HEART ATTACK: NEW HOPE, NEW KNOWLEDGE, NEW LIFE: Second Edition; by Myron Prinzmetal, M.D.; Published by Simon and Schuster, New York, 1965; 232 Pages; Price, $4.50 cloth—$1.75 paperback.

The author, an eminent cardiologist, has collaborated with a grateful patient in preparing a layman's guide to the rehabilitation of a coronary occlusion.

In the early chapters considerable emphasis is given to the anatomy and physiology of the heart and coronary circulation. This information is then used to explain the symptoms and physical findings during an acute myocardial Infarction.

The author then assumes that the patient will be an uncomplicated case and proceeds to give advice on cholesterol, diet, tobacco, exercise, anxiety, and sex.

The dietary content of various lipids is discussed in great detail. Of special interest to the author is cholesterol. Less attention is paid to overall body weight and total caloric intake than to saturated and unsaturated fats.

Exercise is discussed. Some daily exercise, in keeping with the pre-coronary activities of the patient, is needed. For most urban dwellers walking is practical and effective.

Several appendices give sample diet menus with recipes. A caloric and fat content section of most common foods is included.

W. C. Alvarez, M.D., in his preface, states that this book is to be given to the patient whose doctor is too busy to answer all questions concerning his illness. It would seem presumptuous of the author to assume that his approach could satisfy all ranges of emotion and intelligence. At best, this type of book can only supplement the physician's particular knowledge of each patient's needs.

Of those books available, Doctor Prinzmetal's is one of the more broadly conceived. However, the physician who takes the time to discuss the nature of this disease with his patient will probably find the usefulness of the book limited to a few selected cases.

Morris M. Weiss, Jr., M.D.

when even southern sun fails to warm cold hands and feet

provide rapid, sustained vasodilation for warmth and relief of pain, dizziness and faintness in patients with impaired peripheral circulation

GERILIQUID warms cold hands and feet through the thermogenic action of glycine and through sustained vasodilation by glycine and niacin. In addition, in patients with impaired peripheral circulation, GERILIQUID increases the ability to walk farther with less pain. Patients particularly like the palatable, sherry wine base.

Geriliquid®



IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.
Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.
Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.
Supplied: Bottles of 8 oz. and 16 oz.

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PUBLIC HEALTH PAGE

Progress of Fluoridation in Kentucky*

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health, Commonwealth of Kentucky

IN 1945, two large-scale flouridation studies were undertaken at Grand Rapids, Michigan and Newburgh, New York. By 1950, results of these and other large experimental studies showed a startling decline in the decay rate of children's teeth in communities adding fluoride to their water supplies.

Meanwhile scientists studied the effect of fluorides on other parts of the body from every aspect.

The evidence was convincing. Fluoridation was shown to be effective and safe. In 1950, the U. S. Public Health Service and the American Dental Association endorsed fluoridation of water supplies. The following year the American Medical Association approved it.

With this evidence of effectiveness and safety and endorsement by the health agencies, several Kentucky communities instituted measures to fluoridate. Maysville, the first Kentucky community to fluoridate, started in April 1951 and was soon followed by Greensburg in the same month, Elizabethtown in July, Louisville and Hopkinsville in August.

Post-fluoridation surveys have shown the expected 60% reduction in tooth decay. The reduction is evident in both the permanent and primary teeth of the children.

During the 14 years since 1951, sixty additional communities have fluoridated their water supplies giving an accumulated total of sixty-five cities now providing this benefit to their people. The sixty-five communities encompass approximately 1,095,849 people; over one-third of Kentucky's population and 62% of those on community water supplies.

Kentucky ranks fourteenth among the states comparing the percentages of people on communal water supplies who have access to fluoridated water.

Three sizable population areas in Kentucky have as yet not fluoridated their water supplies. These areas are Bowling Green, Covington-Newport and Paducah. If these communities were fluoridated, Kentucky would rank much higher than it presently does.

Although our record of communities providing this health measure for their people is not one to be ashamed of, it is nonetheless a little tragic that 38% of our people on community water supplies are still being denied this benefit fourteen years after our first community fluoridated.

No public health measure has ever been subjected to so much critical analysis, study and investigation. Out of this study comes one irrefutable fact: There is not one whit of scientific evidence to deny that water fluoridated at the proper level prevents much tooth decay and is absolutely safe.

Fluoridation for the average Kentucky community costs initially only about $1400.00 for equipment and after installation approximately $1.25 per million gallons of water. This cost has been estimated to average out, including amortization of equipment, to about ten cents per person per year.

*This article was prepared by E. B. Gernert, D.M.D., M.P.H., director of Dental Health, Kentucky State Department of Health, 275 E. Main Street, Frankfort, Ky.

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: **ACTIONS AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (Iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

in iron deficiency anemia for rapid and predictable replacement of iron reserves

imferon®

(iron dextran injection)



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The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say **things go better with Coke**
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In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients . .

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Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

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MARGARET KELLY, R. N., Director of Nurses

a rapid lift from the hell of depression



Doré Illustration
from
Dante's Inferno

often relieves mental pain in 2-5 days

NORPRAMIN®
(desipramine hydrochloride)

Norpramin is a rapid-acting specific drug for the treatment of depression. Depressive signs and symptoms—sometimes described as "mental pain"—typically begin to improve in 2-5 days. Patients are more hopeful, less empty and less weighed down by their troubles. Norpramin has only slight sedative qualities, nevertheless anxiety *secondary to depression* is frequently relieved as depression is lifted. If anxiety or tension persists it can be controlled by adding a tranquilizer or by reducing dosage. Norpramin is not a MAO inhibitor. Side effects are usually mild.

DOSAGE AND ADMINISTRATION

Optimal results are obtained at a dosage of about 150 mg./day—two 25 mg. tablets t.i.d. After achieving optimal results, a maintenance dose (50-100 mg./day) should be sought.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

IN BRIEF:

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

Contraindications and Precautions: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established.

Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

Supplied: Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

Founded in 1904

HIGHLAND HOSPITAL, INC.

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Affiliated with Duke University





A non-profit, psychiatric institution, offering therapeutic milieu, group and individual psychotherapy, and standard somatic treatments. Limited day-patient and out-patient services. The hospital is located in a 75-acre park amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation.

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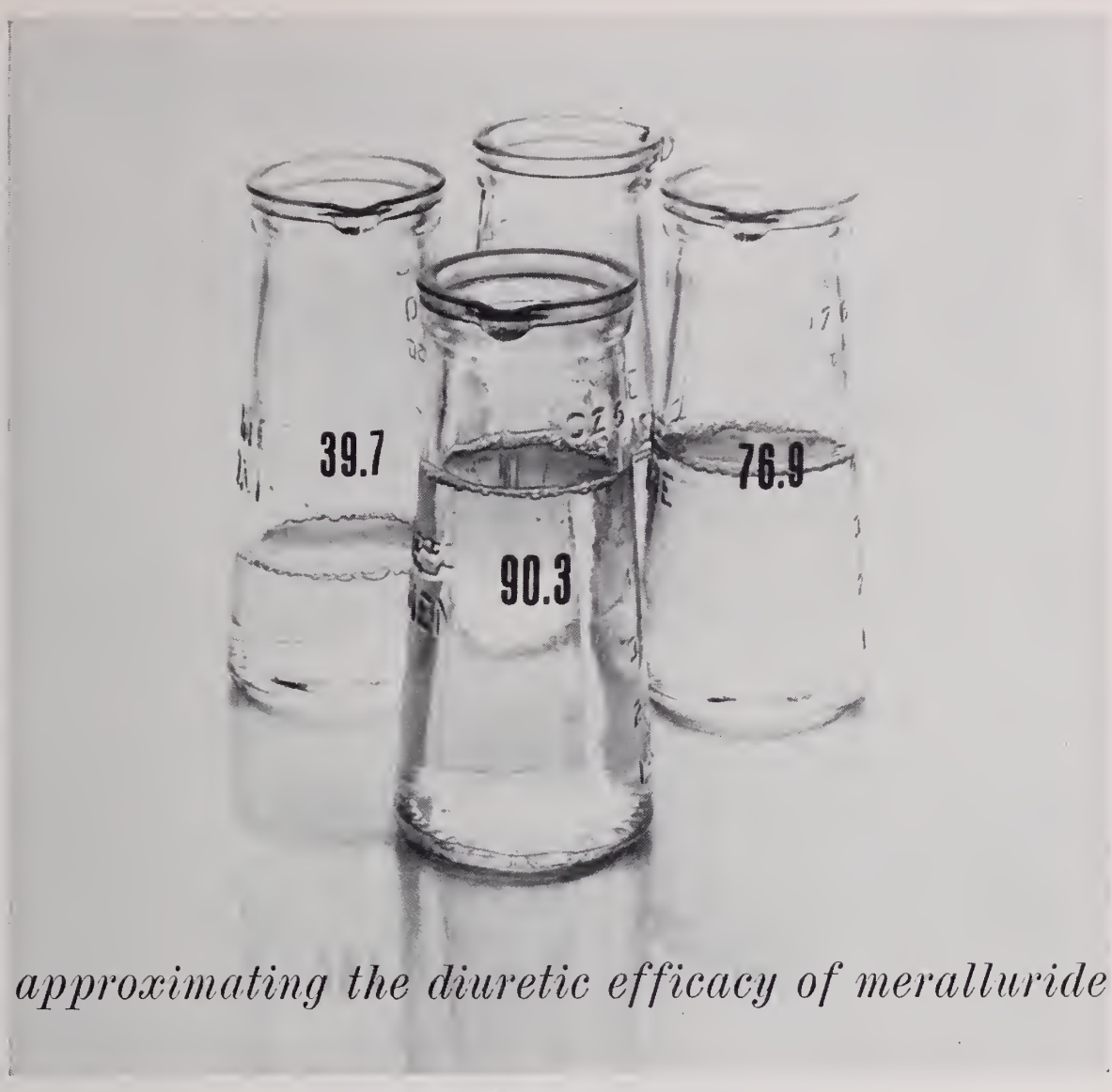


... in the **SOUTHERN OPTICAL BUILDING,** 640 S. 4th St., between Broadway and Chestnut ... where a man is king. In its masculine surroundings, you'll experience the same comfort while being fitted for glasses as you do when being fitted for clothes.

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Contact Lens and Artificial Eye Service on Opthamologist's Prescription Only



approximating the diuretic efficacy of meralluride

METAHYDRIN®

(trichlormethiazide)

To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their fall and winter meetings. At the same time they are choosing the topics to be discused, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in The Journal. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Kentucky 40205.

IN KENTUCKY

JULY

21-22 KAGP Big Sandy Seminar, Jenny Wiley State Park, Prestonsburg

AUGUST

5 KAGP Bardstown Seminar, Bardstown High School, Bardstown

21-22 KAGP Bluegrass Seminar, Imperial House, Lexington

SEPTEMBER

21-23 KMA ANNUAL MEETING, Convention Center, Louisville

OCTOBER

7 KAGP Maysville Seminar, Mason County Health Department, Maysville

21 KAGP Symposium on Industrial Medicine, Stouffer's Louisville Inn, Louisville

IN SURROUNDING STATES

JULY

16-17 Rocky Mountain Cancer Conference, Denver

19-23 Gordon Research Conference on Scientific Information Problems in Research, New Hampton, Rhode Island

26-30 "Interpretation and Therapy of Cardiac Arrhythmias," Cardiovascular Institute, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania

AUGUST

22-27 American Academy of Physical Medicine and Rehabilitation, Sheraton Hotel, Philadelphia

22-27 Flying Physicians Association (11th Annual), Deauville Hotel, Miami Beach

30-Sept. 2 American Hospital Association, San Francisco

SEPTEMBER

9-11 American Association of OB-GYN, Homestead, Hot Springs, Virginia

10-12 National Conference on Physicians and Schools (10th), Sheraton-Chicago Hotel, Chicago

14-17 American Association of Blood Banks, Americana Hotel, Bal Harbour, Florida

19-24 Michigan State Medical Society (Centennial Session), Sheraton-Cadillac Hotel, Detroit

21-24 Pennsylvania Medical Society, Chalfonte-Haddon Hall, Atlantic City, New Jersey

27-28 Tennessee Valley Medical Assembly, Tivoli Theater, Chattanooga

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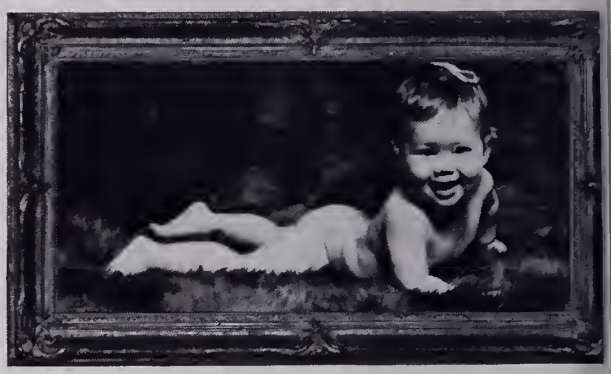
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1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957

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The Diagnosis and Clinical Management of Congenital Dysplasia and Congenital Dislocation of the Hip in Infancy†

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St. Louis, Mo.

Examination of the hips in young infants makes possible the early diagnosis of congenital dsyplasia and congenital dislocation and permits the institution of very simple treatment which assures excellent results in essentially all cases.

ANY discussion of congenital dysplasia and congenital dislocation of the hip in the infant child should be opened and closed with a plea for routine examination of every young infant for possible abnormality of the hip. The examination is simple, can be made by the obstetrician shortly after delivery, by the pediatrician or by the general practitioner at any time during the first few months of life. The earlier the diagnosis is made, the more simple is the treatment and the more certain is the result.

Congenital Dysplasia

The term dysplasia of the hip is used to designate a subluxation in which the acetabulum is not adequately formed and the femoral head is displaced somewhat in relation to the acetabular fossa, although not completely dislocated. The three classical physical signs of congenital dysplasia of the hip are:

1. Limitation of abduction.
2. One or more extra skin creases in the thigh of the involved extremity.
3. Shortening of the involved extremity in a unilateral involvement.

The most significant of these signs in the young infant is limitation of abduction. To check for this sign, the examiner places the infant flat on



FIGURE 1. Congenital dysplasia of the right hip in infant three months of age.

† *Presented at the September 30 General Session of the Kentucky Medical Association Annual Meeting in Louisville, September 29-October 1, 1964.*

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FIGURE 2. Left. Appearance of right hip after treatment by simple abduction of the two hips for a period of three months. FIGURE 3. Right. This film shows the same hip at end of eight months with essentially normal development. Abduction treatment was discontinued after six months.

the back, flexes the hips to 90° and abducts the extremities. In a normal hip, the thigh can be abducted to the extent that it will often touch the surface of the examining table. If the hip is dysplastic, however, abduction is limited. Although these signs are not infallible, the presence of any of these signs should be followed by x-ray examination (Fig. 1), and the child should be referred to an orthopaedist for consultation and possible treatment.

The treatment of congenital dysplasia of the hip in the young infant is extremely simple. It consists merely of placing the hip in a position of abduction sufficient to place the femoral head in the floor of the acetabulum (Fig. 2) and maintaining this position until satisfactory development of the hip has occurred. (Fig. 3). The time required, as a rule, is approximately six months. It matters not how the position of abduction is accomplished. A mass of extra diapers can be used between the two thighs or one may use a Frejka splint, a small pillow covered with water-resistant material, plaster casts on the two extremities connected with a crossbar or any of the commercial splints used for maintaining the position of abduction. The hips should not be forced into an extreme position of 90° abduction. This degree of abduction can increase the intra-articular pressure within the hip and the pressure on the soft cartilaginous capital epiphysis to the extent that secondary pressure changes within the capital epiphysis may result. Abduction of approximately 45° is usually sufficient and the degree of abduction required should be determined by subsequent x-ray examination. That position of abduction should be maintained which will place the capital epiphysis well within the floor of the inadequate acetabulum. The abduction splint may be removed for bathing and for change of diapers as needed but should be worn at all other times during the first few months of life. Once adequate development of the acetabulum has been proven by x-ray studies, the splint may then be discontinued during the day but may be used as a night splint for an additional period. Treatment of this type in the dysplastic hip may be of value in the infant up to two or three years of age, but if the treatment can be instituted at an early age, remodeling of the acetabulum will take place much more rapidly and much more satisfactorily. In the child of walking age, however, a much more radical approach may be required. The importance of the early diagnosis of this problem, therefore, is readily appreciated.

The question is often asked whether or not treatment of this condition is essential in all infants suspected of having such a defect. Occasionally congenital dysplasia of the hip can undergo spontaneous correction without treatment. It is impossible, however, to tell in the beginning whether or not this will occur and since the treatment needed is so simple and conservative, it is a gross error to let any suspected problem continue without treatment.



FIGURE 4. Complete dislocation of left hip in infant four months of age.



FIGURE 5. Appearance of left hip five years later. Active treatment consisted of manual reduction, followed by six months of plaster immobilization as outlined in text.

Congenital Dislocation

Congenital dislocation of the hip (Fig. 4), in my opinion, exists as a separate and distinct clinical entity and, although similar to congenital dysplasia of the hip, it does not follow that actual dislocation invariably results from untreated congenital dysplasia. The physical signs in congenital dislocation of the hip include those previously mentioned for congenital dysplasia and the only additional and differentiating sign between the two conditions is demonstrable telescoping in the involved hip. Differentiation between these two conditions is not always easy. It is not essential for the general practitioner or the pediatrician to distinguish between the two before referring the infant to an orthopaedist for treatment. If the differentiation is not clear, the hip can be treated initially as a congenital dysplasia and if this does not suffice, more active treatment directed toward the actual dislocation can then be substituted.

In my experience, simple abduction methods of treatment are not sufficient for true dislocation. Most dislocations must be reduced manually but force applied to the hip and the extremity in an atempt to accomplish this reduction should be avoided at all costs because of the danger of damaging the soft cartilaginous capital epiphysis. For the reduction, an anesthetic is given in order to keep the child quiet and permit complete control of the hip at all times. The reduction is accomplished by simply flexing the hip, lifting the femoral head into the acetabulum with one hand grasping the knee and with one finger of the opposite hand placed behind the greater trochanter, then rotating the hip externally. The position thus produced is known as the "frog position". Except for the primary anterior dislocation, this position will usually stabilize the hip joint in a child of infant age. This position represents the position of choice in a child of this age because this represents the normal resting position for the hip; this position has been maintained during in utero life and the soft tissues about the hip have not stretched sufficiently at this age to permit complete extension of the hip without undue tension.

Let me repeat, therefore, the frog position represents the position of choice for immobilization of the dislocated hip in the young infant. This position is maintained by plaster casts and immobilization is maintained for approximately six months. During this period of time, the hip is gradually lowered into a position of extension and corrected to midposition with regard to rotation. The first cast is changed after approximately two months with the hip then extended to a position of about 45° flexion and external rotation corrected approximately 50%. After two months, or four months after the original reduction, the cast is again changed and the hip at this time is placed in complete extension and in midposition with regard to rotation. The position of abduction, however, is maintained throughout this time.

The plaster casts can usually be removed at the end of six months and at this time satisfactory development of the acetabulum and satisfactory position for the capital epiphysis in re-

lation to the acetabulum can usually be proven by x-ray (Fig. 5). No additional treatment is required, as a rule, although night splints may be used for some time and with these a position of abduction is maintained during sleep. In the treatment of congenital dislocation of the hip, it is important that these extremities not be forced in the position of 90° of abduction at the hip. A position of abduction is maintained only to the extent necessary to maintain stability for the involved hip. Very often this represents a position of no more than 45° of abduction. If the hip is forced into a position of 90° of abduction, pressure on the capital epiphysis may be increased to such an extent that avascular necrosis will follow.

Bilateral congenital dislocation of the hip in the young infant may be managed in this same manner and both hips can be lifted into position simultaneously and immobilization for each carried out during a single period of treatment. Occasionally, even in the young infant, sufficient femoral torsion will be encountered that it may be advisable to follow the usual treatment with a derotational osteotomy. The presence or absence of significant femoral torsion, however, has no bearing on the diagnosis or the institution of early treatment and the decision with reference to this point should be left to the treating orthopaedist.

A primary anterior congenital dislocation of the hip is occasionally encountered in the young infant and this possibility should be kept in mind if any difficulty is encountered in the usual treatment as outlined. In primary anterior congenital dislocation of the hip, immobilization in plaster is carried out in a position of flexion and abduction and in internal rotation of the hip rather than external rotation. Treatment beyond this point is carried out in much the same manner, although the position of internal rotation should be maintained during the entire period of plaster immobilization. This should then be followed with a derotational osteotomy in order to correct the femoral torsion which is invariably present in the primary anterior type. This again represents a condition which is of great importance to the treating orthopaedist but it has no bearing on the recognition of the basic problem or the decision to institute treatment. Congenital dislocation of the hip in the young infant can be treated in the manner outlined above with assurance of obtaining excellent results in almost all patients. Once the child has reached walking age, the normal resting position for the hip changes from flexion to extension and the position in which the extremity is immobilized following reduction should be changed to one of extension, abduction and internal rotation in the majority of instances. The exact age at which this altered approach to treatment should be used cannot be stated as it varies with the individual child, but this probably occurs about the age of eight or nine months. Beyond this age, a more radical approach is usually required. We will not undertake a discussion of treatment in this older infant group but it can be stated that the results in the older child are more uncertain.

Recapitulation

Let me repeat in closing the great importance of examining the hips in every new born child or at least during the first few weeks of life for the possibility of congenital dysplasia or congenital dislocation of the hip. When this is done and the condition is recognized early, treatment can be instituted at an age where simple therapeutic measures will suffice and a very high percentage of essentially normal hips can be obtained. In the older child more radical measures are required and in many instances the results are not as satisfactory. These examinations must be the responsibility of the obstetrician, the pediatrician or the general practitioner who sees this child at an early age. The examination of the hips requires no more than one minute. If any abnormality is found which suggests the possibility of an existing developmental abnormality in the hip, x-rays should be obtained and the child should be referred to an orthopaedist for consultation and treatment.

Treatment of Cardiac Failure from Aortic Valve Disease With a Ball-Valve Prosthesis in 13 Patients†

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Lexington, Ky.

Ten of thirteen patients with cardiac failure from aortic valve disease are asymptomatic following insertion of an aortic ball-valve prosthesis. The five oldest patients (ages 54-63) all survived despite the presence of severe cardiac failure.

Introduction

IN 1963 a ball-valve prosthesis (Starr-Edwards) first became available for replacement of diseased aortic valves.[4] Before this time, aortic valve replacement had been performed with prosthetic cusps constructed from Teflon cloth.[1] Insertion of the individual prosthetic cusps was difficult, did not always produce a totally competent aortic valve, and late follow-up studies have found a high frequency of stiffening of the cusps.[2] The ball-valve prosthesis has the dual advantage of simplicity of insertion and the certainty of being completely competent. This report describes how these advantages have progressively enlarged the indications for operation to include older patients in severe cardiac failure who were previously considered inoperable.

Methods

Pre-operative evaluation. Operation was undertaken only in patients disabled with cardiac failure from their aortic valvular disease. The data from these patients are shown in Table 1. The severity of aortic obstruction was routinely evaluated by cardiac catheterization* by calculating the cross-sectional area of the aortic valve from simultaneous measurement of cardiac output and pressure gradient between the left ventricle and aorta. Severe obstruction was usually present, with pressure gradients between 100 and 150 mm. Hg. Severe cardiac failure was found in five patients with elevation of the left ventricular diastolic pressure to 20 to 40 mm. Hg. Three patients also had an associated mitral stenosis. Other studies included a chest roentgenogram to measure the degree of cardiac enlargement and an electrocardiogram to evaluate ventricular hypertrophy.

From these studies the urgency and risk of operation could be estimated. On the premise that these desperately ill patients could not survive *without* surgery, no patient was excluded from operation, even though some were desperately ill with recurrent pulmonary edema. One was operated upon (No. 7, Table 1) as a semi-emergency after intensive medical therapy, including phlebotomy, did not relieve pulmonary edema. A similar critically ill patient (No. 10, Table 1) developed ventricular fibrillation in the operating room following induction of anesthesia; this was treated with external cardiac massage and defibrillation after which operation was successfully performed.

Operative technique. All operations were performed with a disc oxygenator and DeBakey roller pumps, priming the oxygenator with heparinized blood diluted with glucose and Dextran. A flow rate of 2.5 liters/M^2/min. was used with moderate hypothermia (25°C.). Intermittent coronary perfusion (5-7 min. perfusion for each 10-15 min. of aortic occlusion) was performed while the aorta was open, perfusing 150 to 250 ml./min. into each coronary ostium. In the last two patients operated upon, continuous coronary perfusion was performed through small polyethylene cannulae inserted

†*Presented at the 1964 annual meeting of the Kentucky Surgical Society at Vanderbilt University School of Medicine, Nashville.*

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into each coronary artery. Dense calcific deposits (7-10 mm. thick) were regularly found involving the leaflet and the annulus. These tough, bony crustations were carefully removed in order to provide an adequate bed for fibrous tissue to grow into the prosthetic valve seating ring. During removal of the friable calcified cusps, particular care was taken to avoid losing any calcium fragments into the left ventricular cavity, which might subsequently embolize into the peripheral circulation. The valve prostheses were sewn with 20-30 closely placed mattress sutures of 2-0 Dacron to the aortic annulus. Following closure of the aortotomy and rewarming to 37°C., the heart defibrillated easily with 1-2 electrical shocks (110-160 volts, 0.1 sec.). The duration of perfusion varied from 90 to 150 minutes. A left ventricular vent was routinely employed to displace air from the heart and to keep the left ventricle decompressed until it was functioning adequately.

In three patients an associated mitral stenosis was treated with a commissurotomy under direct vision before the aortic prosthesis was inserted. The mitral valve was exposed through an incision in the left atrium made anterior to the point of entry of the right pulmonary veins.

Postoperative care. Following operation, all patients were carefully monitored in an intensive care unit for two or more days. A cardioscope was used to detect promptly any changes in cardiac rhythm. Cardiac function was serially evaluated from intracardiac pressures and cardiac output. These measurements were obtained through small polyvinyl catheters inserted at operation into the left atrium, pulmonary artery, peripheral vein and radial artery.

TABLE 1

Data From 13 Patients With Aortic Valve Disease and Heart Failure

Patient No.; Initial	Age (years)	Diagnosis*	Cardiac Failure Degree	Treatment	Time Since Operation (months)	Results
1; W. H.	24	AI	Moderate	Ball-Valve Prosthesis	12	well
2; R. L.	61	AS; AI	Severe	Ball-Valve Prosthesis	12	well
3; O. W.	59	AS; AI	Severe	Ball-Valve Prosthesis	➤	fatal endocarditis 3 mos. postop.
4; M. S.	59	AS	Moderate	Ball-Valve Prosthesis	10	Some limitation of physical activity
5; C. C.	24	AI; MS	Moderate	Ball-Valve Prosthesis; Mitral Commissurotomy	10	well
6; M. E.	13	AI	Moderate	Ball-Valve Prosthesis	9	well
7; H. G.	54	AS; AI	Severe	Ball-Valve Prosthesis; Tracheostomy	5	well
8; P. C.	37	AS	Moderate	Ball-Valve Prosthesis; Tracheostomy	➤	Operative Death
9; D. P.	33	AS	Moderate	Ball-Valve Prosthesis	4	well
10; L. C.	35	AI; MS	Moderate	Ball-Valve Prosthesis; Mitral Commissurotomy	2	well
11; W. D.	45	AS; AI	Severe	Ball-Valve Prosthesis; Tracheostomy	2	well
12; M. R.	53	AS; AI; MS	Moderate	Ball-Valve Prosthesis; Mitral Commissurotomy	➤	Operative Death
13; J. R.	63	AS; AI Myocardial Infraction	Severe	Ball-Valve Prosthesis; Tracheostomy	1	convalescing

*AS: Aortic Stenosis, AI: Aortic Insufficiency, MS: Mitral Stenosis.

Subsequently the catheters were simply withdrawn. In four patients a tracheostomy and mechanical ventilation were employed for 2-3 days because of the severe pulmonary congestion present before operation.

Anticoagulant therapy with Coumadin was begun 5-6 days after operation and maintained thereafter, keeping the prothrombin time between 20 and 30 seconds.

Results

There were two operative deaths among the 13 operations. One resulted from a hemorrhagic diathesis associated with a fibrinolysin. The other followed displacement of the prosthesis after the anchoring sutures had cut through an inadequately debrided, calcified annulus. The prosthesis was resutured at a second operation, but the associated cardiac and respiratory injury were fatal.

One other death occurred in a 55-year-old patient explored for aortic stenosis and insufficiency who is not listed in Table 1. This patient was found to have obstruction from diffuse hypoplasia of the outflow tract of the left ventricle in conjunction with aortic valvular disease. The aortic lumen was too small for the smallest aortic prosthesis available (size #8, Starr-Edwards) despite repeated efforts to widen the left ventricular outflow tract. Attempted reconstruction of the aortic valve with small Teflon cusps was subsequently unsuccessful.

The most remarkable aspect of valvular substitution in these salvage cardiacs was the prompt return of a normal cardiac output once a competent valve had been inserted. In four patients, the left ventricular diastolic pressure decreased from 40 mm. Hg. before bypass to 10 mm. after its completion.

Cardiac arrhythmias such as atrial fibrillation, nodal rhythm and bundle branch block were monitored with a cardioscope, and were common for 1-5 days following surgery. These disturbances probably resulted from sutures in the base of the noncoronary sinus producing edema around the bundle of His. Fortunately, all of the arrhythmias were transient.

Following discharge from the hospital, one patient (No. 3, Table 1) was asymptomatic for three months, but then developed a fatal endocarditis on the prosthesis. This infection was the only one in the entire group. Ten patients are doing well 1-12 months following operation. Most are receiving anticoagulants, though none has had any peripheral emboli. Physical activity had not been limited, and some of the younger patients are performing strenuous physical labor.

Discussion

The fact that the five oldest patients (54-63 years of age) all survived operation despite severe preoperative cardiac failure was surprising. This apparently was due to the immediate improvement in left ventricular function following insertion of the aortic prosthesis. Though the total number of patients is small, these experiences indicate that operation may be hopefully undertaken despite the presence of severe cardiac failure. Without the operation, the prognosis following the onset of cardiac failure from aortic valvular disease is dismal. In one group of 61 such patients reported by Harken, 55 died within six monts.[3]

The limited long-term experience with aortic prostheses suggests their use at the present time should be restricted to patients in cardiac failure. Experimental and clinical evidence indicate that complications such as emboli or displacement of the prosthesis are most likely to occur within the first few months after operation. Additional information is needed regarding function one to four years after operation, just as is now available for the comparable mitral ball-valve prosthesis, which has shown no sign of impaired function for periods up to three years following insertion.

Summary

Thirteen patients with serious cardiac failure from aortic valvular disease have had the aortic valve replaced with a ball-valve prosthesis. There were two operative deaths, one from hemorrhage and one from dislodgement of the prosthesis. One other death occurred three months following operation from bacterial endocarditis. All other patients are well and free of symptoms; anticoagulant therapy is given for an indefinite period though emboli have not occurred.

Operation was undertaken in all patients, re-

(Continued on Page 536)

Cavitary Cryptococcosis

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Two cases of pulmonary cavitation due to Cryptococcus Neoformans (Torula) are presented. The occurrence of this infection in the lung is reviewed. Lobectomy was done with complete recovery. Amphotericin B therapy was not given.

CRYPTOCOCCUS neoformans (Torula histolytica) remains a rare cause of pulmonary disease even though etiologic agents for any of the pulmonary granulomas have been clarified with the advent of better techniques for identification of fungi.[1, 2] To date there have been only 56 reported resected cases of pulmonary cryptococcosis.[3] Even more unusual is the occurrence of cavitary lesions requiring surgery.[4] In view of this, we thought it of interest to present two cases of cavitary cryptococcosis treated by resectional therapy.

Case Reports

Case #1 (R.B.) This 35-year-old white female was noted on a mobile unit x-ray to have a right upper lobe lesion. The lesion measured approximately 5x6 cms. and was a rather dense pneumonic appearing area. It is of interest that the patient has had x-rays taken since 1956 and has been noted to have soft infiltrate in the right upper lobe, but no definite discrete lesion. She was completely asymptomatic. PPD and histoplasmin skin tests were negative. Physical examination was entirely unremarkable. The chest x-ray (Fig. 1) shows a rather sharply circumscribed and somewhat lobulated parenchymal lesion lying at the level of the second rib; some central excavation could not be ruled out. On 4/16/63, the patient underwent exploratory right thoracotomy. On entering the right pleural cavity there were numerous fine adhesions over the upper lobe which were easily freed. The diseased area was in the anterior



FIGURE 1. There is a sharply circumscribed lobulated lesion, second interspace in the right lung, with suggestive area of cavitation.

segment of the right upper lobe adjacent to the right middle lobe area. During dissection and in opening the minor fissure, a diseased area was entered and somewhat odiferous mucoid material was aspirated. This cystic area was adjacent to the minor fissure. The remainder of the dissection in carrying out right upper lobectomy was uneventful, as was the postoperative course. Examination of the pathological specimen revealed extensive necrosis in the anterior segment and a bronchus leading to the segment was greatly dilated and had a saccular appearance. Histological examination revealed active, chronic inflammation with marked fibrosis and peribronchial infiltration of lymphoid cells. The bronchiectatic cavity was lined in part by granulation tissue with many lipoid filled phagocytes. There was no evidence of caseous necrosis and no fungi were noted. The initial impression was that of a bronchiectatic abscess with chronic lipoid pneumonia. However, cultures of the resected specimen grew out organisms compatible with cryptococcus neoformans. This patient has been well and

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without complications for fourteen months postoperatively. No anti-fungal chemotherapy in the form of Amphotericin B was given preoperatively or postoperatively.

Case #2 (R.S.) This forty year-old farmer was admitted in December 1963. His history dated back six months when he developed a non-productive cough and an acute febrile illness. The patient continued with this symptomatology for approximately two weeks, and then developed right pleuritic chest pain. Chest x-ray at that time revealed an infiltrative lesion in the right upper lobe. Repeated laboratory studies for tuberculosis were negative. PPD and histoplasmin skin tests were negative. Physical examination was unremarkable. Chest film on admission (Fig. 2) revealed a densely infiltrative lesion in the right upper lobe with an irregular oval radiolucency overlying the second anterior rib, measuring 1x1½ cms. Because this lesion did not clear on broad spectrum antibiotics, exploratory thoracotomy was advised and performed on 12/13/63. On exploration the lung was moderately adherent to the chest wall over the apex. After completely freeing the lung, the disease was noted to be confined to the right upper lobe. The middle and lower lobers were relatively free of the disease except for some small bullous lesions along the edge of the middle lobe. Right upper lobectomy was carried out uneventfully. Microscopic sections revealed granulomatous inflammation characterized by central caseous necrosis surrounded by epithelioid cells, fibrosis, and giant cells. There were many small granulomatous lesions without caseation. Some calcification was noted in the more caseous areas. Acid-fast stains were negative; however, PAS stains revealed gram positive material with some organisms identifiable within giant cells and in interstitial tissue compatible with cryptococcosis. Culture was also positive for cryptococcosis neoformans. The patient's postoperative course was uneventful and he has remained well six months postoperatively. This patient did not receive Amphotericin B postoperatively.



FIGURE 2. Cavitary lesion with marked pericavitary reaction is present in right infraclavicular area.

Discussion

In the United States about 50 deaths a year are attributed to this disease.[5] Most authors believe that the lungs are the usual port of entry. Transmission of the disease from man to man or from animal to animal has not been reported. Organisms are thought to be air-borne from a reservoir in the soil. The central nervous system manifestations of Torulosis have been well described,[6] as well as its association with preexisting tuberculosis, leukemia, and other malignant diseases of the reticuloendothelial system. It has also been reported as a complication of steroid therapy.

The disease usually runs a slow, benign course unless there is hematogenous dissemination to the central nervous system. This is exemplified in our two cases, the first of which was entirely asymptomatic although x-ray changes were noted for approximately seven years. This disease tends to produce fewer symptoms than would be expected. Cough, hemoptysis and chest pain may ocur. Fever may be present but is usually low grade; weight loss and night sweats are rare.

One of the unusual characteristics of pulmonary cryptococcosis is the rare occurrence of cavitation. Although solitary and multiple masses, disseminated nodular lesions of the miliary or slightly larger type, and varying infiltrative lesions have been described, most authors[3,4,6,7] mention the rarity of cavitary formation as compared with tuberculosis and other mycotic infections. Characteristically, cryptococcosis has a predilection for the lower half of the pulmonary fields, there is usually

minimal or absent fibrosis and calcification, inconspicuous hilar adenopathy and, infrequently, massive pulmonary collapse.[3,6] Kent, et al., have reported the small subpleural nodule as the most common pathologic entity.[7] Bone lesions are rare as compared with blastomycosis.

The first surgical excision of a pulmonary lesion due to cryptococcosis was suggested by Taber in 1937.[8] Froio and Bailey[9] in 1949 described the first surgically cured patient. They reported four localized lesions that were resected. Knudson, et al.,[3] in an extensive review of literature and in a report of three cases, states that most cases are treated by lobectomy, although some by wedge, segmental resection, and even pneumonectomy.[10] In Australia where cryptococcosis is better recognized, pulmonary lesions are resected not only as prophylaxis against central nervous involvement, but also in the hope that resection will affect the course of the disease more favorably, even when meningitis is present. Clinical improvement and apparent recovery has been reported by McConchie, et al.,[11] in two cases of cryptococco-meningitis.

One of the alarming facets of resectional therapy in cryptococcosis has been the postoperative complication of central nervous system involvement. Dormer, et al., in 1945[12] reported such a complication following lobectomy. Palmrose and Losli[13] reported a segmental resection followed by death from cerebral involvement four years later.

Because of the scattered reports of central nervous system involvement following pulmonary resection and the suggested lower complication rate in the resectional therapy of other mycotic infections with Amphotericin B[2, 3, 5] it has been advised that this antibiotic be used in both the preoperative and postoperative period of patients who have undergone pulmonary resection for cryptococcosis.[3] Although neither of our patients in the 7 and 14 month periods of follow-up have had cerebral manifestations, it is advisable that they be kept under close observation. The diagnosis in both cases was not made with certainty for over one month when the organisms were identified on culture studies. Because of this delay in diagnosis, we were unable to convince the patients to undergo the discomfort of receiving an adequate course of Amphotericin B therapy.

Summary

Two cases of cavitary cryptococcosis are reviewed. The paucity of pulmonary symptoms in patients with this disease is of interest. Cavitary cryptococcosis appears to be a very rare clinical manifestation of this fungal infection. Amphotericin B was not used in our cases but since the organism is susceptible to the drug it may be advisable in future cases to prescribe it, especially if there are postoperative complications.

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Amebic Dysentery Presenting as Ulcerative Colitis Report of a Case and its Treatment †

James K. Cooper, M.D.* and William W. Winternitz, M.D.**

Lexington, Ky.

Intractable diarrhea can present a serious problem in diagnosis; an uncommon cause, amebiasis, still occurs in this state, and must be considered.

THE correct diagnosis of intractable diarrhea can present a serious and urgent problem. Every attempt should be made to rule out less common but treatable causes. An example is diarrhea caused by Entamoeba histolytica, which is becoming less frequent in this country. Because of its ease of diagnosis and prompt response to treatment it should not be overlooked. In the case presented, the patient entered the hospital moribund. Diagnosis was made promptly and appropriate treatment instituted. Improvement was rapid.

Case Report

A 75-year-old white man was referred to the University Hospital from another hospital because of intractable diarrhea.

The patient had been living as a semi-recluse for several years. He apparently had been in reasonably good health until three weeks prior to this admission when his son-in-law found him in his home with evidence of having developed fulminant incontinent diarrhea. He was taken to a hospital where he was treated symptomatically with some improvement. After three days he was discharged and went to live with his family. The diarrhea persisted and became bloody, so he was admitted again to the hospital. Barium enema was interpreted as "ulcerative colitis" (Figure 1). He had up to 20 bowel movements a day and passed bright and dark blood. There was some low abdominal cramping pain, but no upper abdominal pain or other complaints such as malaise, fever, or muscle pains. The patient lost 20 pounds, and became confused and quite weak. There had been no similar illness among the patient's family or in his past. His dietary intake was poor and unbalanced, but his alcoholic intake had been regular, although difficult to estimate.



FIGURE 1: Barium enema taken at another hospital. Interpretation there and at University Hospital was "ulcerative colitis".

Treatment during his second admission included paregoric and diphenolylate with atropine (as Lomotil®). He also received seven units of whole blood, and, two days before his transfer to University Hospital, was begun on dexamethasone, 0.75 mgm. q.i.d.

Examination on admission to University Hospital showed a confused, chronically ill man who was dehydrated, incontinent of feces, and appeared frail, but in no pain. There were several small ulcers on the tonsilar pillars, and the heart rhythm was irregular. Otherwise the

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FIGURE 2: Barium enema three months after treatment for amebiasis. Interpreted as "normal".

physical exam was unrevealing. The liver was not enlarged, and there was no abdominal tenderness.

On admission, sigmoidoscopy revealed shaggy shallow mucosal ulcers with raised edges, and marked hyperemia and punctuate hemorrhages. Swabbed samples taken directly from the bases of several ulcers were examined in a warm wet drop preparation immediately. Typical trophozoites of *E. histolytica* were identified. Cysts were later identified in a stool specimen (Figure 3).

Treatment included tetracycline, emetine hydrochloride, quinoline, nystatin, a kaolin-pectin preparation, intravenous fluids, and a low residue diet.

There was marked clinical improvement in 24 hours, and the diarrhea ceased entirely in three days. The patient's temperature remained at around 99°. The drugs were maintained throughout his hospitalization. After 12 days, repeat sigmoidoscopy showed substantial improvement, although some ulcers and hyperemia persisted. The patient was discharged to a nursing home. He was also begun on a four week course of diiodohydroxyquin, an amebicide, to eliminate a possible carrier state.

Local and State Health authorities examined the patient's original water supply and found no contamination.

Second Admission

Three months later the patient was seen in the clinic for a routine visit. Although he denied any symptoms, he was noted to be jaundiced. The liver was palpable 1 to 2 fingerbreadths below the right costal border, but was not tender. He was admitted, and laboratory results and liver biopsy confirmed the diagnosis of hepatitis, which was assumed to be homologous serum jaundice. No specific treatment was given. Upper intestine and large bowel x-rays were normal (Figure 2). Sigmoidscopy was entirely normal. No trophozoites or cysts of Entamoeba histolytica were seen on stool examination.

Discussion

Incidence and diagnosis. The incidence of amebic carriers in the United States was at one time considered to be around 10% of the general population,[1] but it is generally felt that this figure is quite high. Other estimates vary from "considerably less than 1%"[2] to about 4%,[3] but it is still noted to be as high as 10.5% in some rural communities.[4] The disease is primarily one of warm or hot climates,[5] but its occurence in rural parts of the United States cannot be ignored.[6] In some parts of Kentucky, up to 3.3% of the population have been found to carry amebic cysts.[7] Of those who have clinical symptoms of amebiasis, less than 1% have acute dysentery.[8, 9]

In the past one difficulty with surveys indicating carrier incidence has been the failure to differentiate between the "small" and "large" races of *E. histolytica*. Probably most of the "small" race, as usually determined, is not *E. histolytica* at all, but is *E. hartmanni*.[10] *E. hartmanni* is not considered to be pathogenic. Its differentiation requires laboratory skill; however, its trophozoites have never been observed to ingest blood cells, so this phenomenon, as observed in the case presented, apparently characterizes *E. histolytica*[9]. The amebic cysts are antigenically unique, and the application of fluorescent antibody technique may considerably simplify the problem in the future.[11]

However, the clinical picture and proctoscopic findings of the acute case make the diagnosis easy.[12, 13] The proctoscopic findings include the presence of typical ulcers, from 1 mm to several centimeters, with clearcut elevated margins, often with a grayish accumulation in the center. The mucosa may appear normal or

hyperemic[14]; scrapings of the mucosa will reveal typical trophozoites in 90% of the cases if observed immediately.[12]

The pathogenic trophozoite is actively motile, 20 to 30 microns in diameter with a single, delicate, barely distinguishable nucleus.[15] Because of its phagocytic properties, it is often seen containing engulfed red blood cells, which, as noted above, is a distinguishing feature (Figure 3).

The clinical symptoms of acute amebic dysentery are well known, and include diarrhea, weight loss, abdominal pain, and often a low grade fever.[9] Although diarrhea may not be present at first, it may become fulminant, and appear watery with mucous, blood, and cellular detritus. The barium enema is not of specific value in the diagnosis; it can be normal[9], or it may be identical with that of ulcerative colitis[16] as in the case presented.

The clinical symptoms of acute nonspecific ulcerative colitis may be the same as those of amebic dysentery. Ulcerative colitis encompasses a wide spectrum of symptoms,[14] and its treatment is nonspecific. On proctoscopic examination, however, the mucosa should appear edematous with minute pinpoint bleeding. The ulcers are difficult to see, and there is excess mucous. When the ulcers are large, they have irregular and ragged edges.[15] The incidence of this disease seems to be increasing.[14]

Acute bacillary and viral dysentery, malignancy of the colon, intestinal tuberculosis, lymphopathia venereum, and even malaria and infection by some of the helminthes can present a clinical picture of acute fulminant diarrhea.[1] The distinct proctoscopic picture which differentiates amebiasis from these makes this examination imperative in differential diagnosis.

Treatment

Treatment of amebic dysentery includes three general categories of drugs. Emetine is the classic drug, and is generally considered the most effective in dysentery.[5, 17] It suppresses the symptoms promptly, but may have side effects including nausea and vomiting, hypotension, and tachycardia[18]. It is given intramuscularly as emetine hydrochloride, usually 30 mgm twice a day. An oral preparation, which is said to have fewer side effects, is emetine bismuth iodide; however, this drug is not commercially available in this country.



FIGURE 3: Photomicrograph of active pathogenic trophozoite obtained from rectal mucosa of patient. This photo is from a motion picture obtained at microscopic observation.

Antibiotics, especially tetracycline, play an important role in the treatment of the acute case. Although they have no effect on the parasite itself, they do alter the bacterial content of the intestine, to which the activity of the amoeba is intimately related.[19] It was administered in the case presented along with nystatin, which was given to prevent monilial growth.

After the diarrhea has been overcome, the final phase of treatment is to eliminate the carrier state. Because of the possible side effects of arsenic drugs, diiodohydroxyquin seems a better choice than carbarsone. It may be given as 0.6 gm three times daily for three weeks. If necessary, carbarsone should then be tried.

Supportive therapy is given as indicated. Fluids, vitamins, and a low residue diet were used in this case. Chloroquine was not administered as it is not effective in intestinal infection; it is indicated in amebic hepatitis and abscess, since it is concentrated in the liver.

The patient presented developed hepatitis presumably as a result of his blood transfusions. Although he apparently needed blood at the time, had the diagnosis been made earlier, and treatment started, he might have been spared this complication.

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Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses,* until diarrhea is controlled, are:

Children:

3 to 6 months—3 mg. (½ tsp.* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

Adults:

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**Based on 4 cc. per teaspoonful.*

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Summary

A case of amebic dysentery is presented. The diagnosis was overlooked at first because of the rareness of the disease and because of the similarity of this case, clinically and radiologically, to ulcerative colitis.

Carriers of cysts rarely develop acute dysentery. The disease is decreasing and the often quoted figure of 10% incidence of carriers in the general population is probably now too high. Even though dysentery does not develop often in carriers, and there are few carriers, amebiasis should be considered in all cases of significant diarrhea, especially in rural areas where, because of the higher incidence of carriers, more acute disease can be expected.

The procedures necessary for a presumptive diagnosis of amebiasis are discussed. It is important and easy to obtain a warm saline wash specimen from the rectal mucosa and examine it under the microscope for the pathogenic trophozoite. The clinical picture, including x-rays, may be misleading.

Treatment of amebic dysentery includes three classes of drugs. Emetine is given in the acute state and produces rapid symptomatic improvement. Tetracycline is also given since it decreases trophozoite activity by its effect on intestinal bacteria. An amebicide is the third class of drug, although it usually is not given during the acute state. Its importance must not be overlooked, to prevent recurrence of dysentery and to prevent infection of others from a carrier. Diiodohydroxyquin is recommended but carbarsone is probably more frequently used. If liver involvement is suspected, a fourth drug, chloroquine, is used.

It is hoped that in the future, simple and more reliable techniques of finding carriers such as fluorescent antibody methods will be available. In the acute state, however, easy methods of diagnosis (proctoscopy and microscopic examination) are available.

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Botulism: A Danger of Home Canning

Roger M. Spalter, M.D.*

Lexington, Ky.

As long as there is home canning of foods, botulism is a matter of grave concern. The physician needs to be aware of this disease entity and help the lay public understand three steps through which the danger of botulism can be eliminated.

Introduction

RECENTLY, two outbreaks of botulism in Kentucky have come to our attention with the vehicle in both cases being home preserved corn. In addition there have been several articles written concerning contamination of commercial foods with botulinus toxin.[1,2,3] It is the intention of this paper to report on the Kentucky outbreaks, to review the clinical findings in this disease and to discuss the dangers of botulism involved in improper home canning.

Case Reports

The first outbreak occurred in September of 1963. Five members of a family of ten ate varying amounts of home preserved pickled corn during an evening meal.

The 12-year-old daughter, who had eaten two dishes of corn, developed vomiting, diarrhea, abdominal cramps within 12 hours of ingestion. This was followed by generalized muscle weakness and respiratory paralysis. She died on the third day of her illness. The mother and three other children, ages 14, 12 and 5, ate corn in amounts of from one dish to two teaspoonsful, and the severity of their symptoms was related to the amount ingested. They were all hospitalized at the University of Kentucky Medical Center.

Two days after eating the corn, the 14-year-old son, who ingested one dish of corn, developed vomiting, diarrhea and abdominal cramps. Several hours after the onset he noted generalized muscle weakness, diplopia and dysphagia. It was at this point that he was hospitalized at the Medical Center. Physical examination at that time revealed normal vital signs with a temperature of 98°F. He had a mask-like facies with an erythematous flush of his nose, cheeks and ears. No gag reflex could be elicited. Diplopia was noted on lateral gaze. His respiratory effort was decreased with a vital capacity of three liters (normal values three-six liters). Muscle strength was decreased, but the neurological examination was otherwise unremarkable. Blood morphology and urinalysis were normal.

The clinical diagnosis of botulism was made, and over the next 16 hours he was given a total of 45,000 units of bivalent (Types A and B) botulinus antitoxin. By the third day of hospitalization his gag reflex had returned and he was taking fluids orally. Over the next two days, the diplopia and muscle weakness gradually improved, and he was discharged asymptomatic.

The two other children and the mother had similar symptoms and were treated and recovered in a similar fashion.

The corn ingested was prepared in sterilized jars and boiled for four and one half hours. Pickling salt was then added. The corn was stored in the family chicken coop. The mother said that during the period of storage the jar tops were changed several times. The corn was then eaten cold. When the corn was brought in for examination, there was a very definite odor of spoilage. Type B botulinus toxin was demonstrated in one of the jars of uneaten corn.

The second outbreak occurred in December of 1963. Two members of a family of four ate varying amounts of home preserved pickled corn. The nine-year-old daughter, after the ingestion of the corn, rapidly developed diplopia, dysphagia, nasal speech, dyspnea, and staggering gait. Before any treatment could be given, this girl died on the second day of her illness.

On the following day, the 27-month old daughter also developed dysphagia, weakness, and nasal speech. She was hospitalized at another hospital. She showed gradual improve-

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ment over the next three days to the point where she was taking fluids orally. She had been treated with steroids, antibiotics and intravenous fluids. However, within another 24 hours her dysphagia had returned. When she showed no further improvement over the next week, she was transferred to the Medical Center two weeks after the onset of her illness. Physical examination revealed normal vital signs with a temperature of 99°F. She was in a semi-stuporous state, responded only to tactile stimulation, and had no gag reflex. Muscle strength was decreased generally, but the remainder of the neurological examination was unremarkable. A lumbar puncture showed normal protein and sugar, and no cells. A chest x-ray was clear. The diagnosis of botulism was considered, but because of the lateness in the course of the disease no definitive treatment was indicated, and only supportive care was given. During the first seven days she showed no improvement. She remained only minimally responsive, and she had to be tube fed. She handled her secretions poorly and had to be suctioned frequently. During the next week she showed gradual improvement. By the end of this time, she was fully responsive, took oral fluids well and her speech could be understood. She, however, remained somewhat weak at the time of discharge.

At no time during the course of her illness was she given antitoxin to botulism. The pickled corn, which only the two children had eaten, contained Type B botulinus toxin. However, no information was elicited about the canning which would indicate the source of contamination of the botulinus organisms. Differing from the first outbreak, this corn did not appear or smell spoiled.

Comment

Incidence: In 1963, in the United States, there were a total of 12 outbreaks of botulism accounting for 46 cases with 14 deaths; not including the second outbreak of two cases and one death reported in this paper.[4] The 46 cases were the highest total since 1939 and were largely due to 24 cases from commercial food products. Kentucky, in addition to the two outbreaks described in this paper, had one other outbreak with two cases and no deaths in 1963. The vehicle was commercial white fish chubs. In the ten year period 1950-59 Kentucky had 11 cases of botulism whereas in the four years of 1960-63 there were 10 cases.

Etiology: There are five known strains of Clostridia which can be distinguished by the antigenic type of toxin produced. Types A and B are most commonly involved in human illness; Type E which is found chiefly in fish and fish products is a less common source. Types C and D have not been known to affect humans.

The toxin is liberated into the environment, the food, during autolysis of the bacteria. It is the toxin alone which produces disease by paralyzing the efferent autonomic nervous system. The site of action is at the neuromuscular junction with effect on only the cholinergic system. It is thought that the basis for paralysis is interference with the release of acetylcholine.[5]

Symptoms: Onset of the disease may vary between 12 to 96 hours after ingestion of the food. Symptoms may persist up to six months and may include visual disturbances with diplopia, dysarthia, dysphagia, and progressive muscular weakness. Gastrointestinal symptoms of nausea, vomiting, and diarrhea occur in approximately one-third to one-half of the cases. Temperature is usually normal to subnormal. Death is usually due to respiratory paralysis.

Since diarrhea is not a common symptom of the disease its occurrence in our first outbreak may have been due to other contaminants in the food inasmuch as the corn in this case was very foul smelling.

Treatment: The only definitive treatment available is with type-specific botulinus antitoxin. This, however, acts only on the circulating toxin and does not neutralize toxin already fixed to the tissues. Therefore treatment must be begun early to tie up the circulating toxin before it is fixed to the tissues.

Epidemiology: In the epidemiology of botulism, several factors have to be considered in relation to home canning of foods. (1) The spores which are found distributed in the soil must remain on the food while it is being canned and must survive processing by heat or steam pressure. (2) The surviving spores must germinate and grow under anaerobic conditions in the canned food, and certain conditions of temperature, salinity, and acidity have to be overcome in order for these organisms to grow. (3) The toxin, which is being released by the organism, must not be inactivated by heating of the food before eating. (4) The toxin must

then be ingested by the individual to produce disease.

Preventions: In the prevention of botulism the first three factors considered above must be dealt with.

(1) Since spores are rather resistant to both heat and chemicals, it takes 300 minutes of heat at 100°C., 120 minutes at 103°C., or 10 minutes at 120°C. to kill most suspensions of spores.[6] The boiling water method in home canning is adequate for processing fruits, tomatoes and other highly acid foods. However, because of pH and salinity factors, the steam pressure method should be used for processing beans, beets, corn, meats and all other low acid foods.

(2) It has been shown that in food a pH less than 4.7 will generally inhibit growth of most organisms.[7,8] Most high acid foods therefore will not need the intense heat supplied by a steam cooker to destroy the spores. However, steam cooking is the only method which supplies enough heat to destroy the spores in a short time or in low acid food where the pH might not inhibit growth.

A salt content of greater than 8% is also sufficient to inhibit growth of most organisms.[7,8] The small amount of salt added for flavoring in some foods is obviously not adequate to do this, but in pickling of foods there should be enough salt to prevent the growth.

It has also been shown that a temperature below 37°F. will inhibit growth of most organisms.[8] Therefore, foods that are frozen after processing should be free of toxin.

(3) Even if factors are favorable for toxin production, boiling the canned food for 15 minutes prior to eating will inactivate the toxins and prevent disease. Botulinus toxin is different from the spores in that it is very heat labile.

In our first case report we can only surmise how the organisms got into the food and produced the toxin. The jars were opened several times after the corn had been boiled. The spores could have been introduced somehow at these times. The spores could have been in the pickling salt that was added after boiling, but no answer can be given as to why the organisms grew in spite of the salinity of the media. We can, however, conclude that it is important not to have any deviations from the accepted methods of home canning foods.

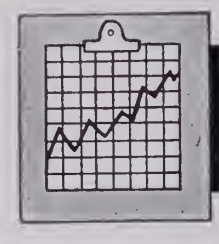
Conclusion

It is generally accepted that foods which appear or smell tainted should never be tasted. However, since some foods will show no evidence of spoilage and yet be contaminated with the botulinus organism, there are certain points in relation to canned foods which must be realized if the danger of botulism is to be limited. Food that is home canned should be boiled at least three hours or steam cooked under adequate pressure. Temperature, salinity, and acidity alone cannot be relied upon to inhibit the growth of botulinus organisms. Therefore, food that is home canned should be boiled for 15 minutes prior to eating to inactivate any toxins that may be present.

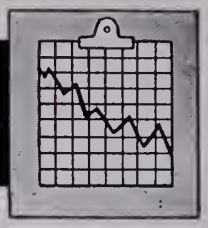
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At the KMA Annual Meeting see
97 Carefully Selected
Scientific and Technical Exhibits
Sept. 21 - 23, 1965



CASE DISCUSSIONS
From The
University of Louisville Hospitals



Louisville General Hospital

Large Ovarian Tumor in Poor Risk Geriatric Patient

L. G. H. Protocol #196618. G. I., an 87 year-old negro woman, was admitted on May 14, 1964, with the chief complaint of abdominal distension. The patient stated that she was entirely well until six days before admission, when she began to note overnight swelling of the left leg followed by marked distension of the abdomen. The complaint was sufficiently severe to keep her in bed. For two to three weeks prior to admission, she had complained of poor appetite with occasional episodes of nausea, and had noted a relative weight loss. The past history was non-contributory except for the notation that the patient had a right mastectomy in 1936 for an indeterminate diagnosis.

Physical examination on admission showed an 87 year-old negro woman who was extremely emaciated. She was only relatively cooperative because of her senility. The blood pressure was 100/70, pulse 88, respirations 28, and temperature 98.6°. She appeared to be having difficulty in breathing because of a large abdominal mass. The right breast was absent, and in its place was a well healed scar. The abdomen was immensely swollen, and was markedly tense and distended. No fluid wave was palpable. Bowel sounds were hypoactive. Percussion of the abdomen showed dullness anteriorly with tympany in the flanks. On pelvic examination, there were multiple nodular sebaceous cysts on the vulva, and a moderate cystorectocele. The cervix was small, smooth and pale. The uterus could not be separately palpated, nor could the adnexa. The inferiormost portion of a large intra-abdominal cystic mass could be felt on the right side. The left leg was markedly swollen, edematous and painful. The initial impression was that of encapsulated ovarian neoplasm, or ovarian carcinomatosis with dehydration. Admission hemoglobin was 10.2 gm, but when the patient's fluid balance was restored somewhat, the hemoglobin fell to 8.6 gm. She received two units of packed red cells. A consultant then recommended a diagnostic laparotomy.

On May 26, 1964, the abdomen was opened. A large bluish cystic mass weighing 23 pounds arose from the right ovary. It was completely encapsulated. The liver was free from evidence of metastasis, and there were no implantations or nodules on the peritoneal cavity. Extension of the incision to the xiphoid permitted delivery of the large mass from the abdomen. The pedicle was clamped and the mass removed. Following removal of both masses, the patient had an episode of hypotension, and the operation was terminated as soon as possible after hemostasis had been secured.

Postoperatively, there was difficulty in securing adequate ambulation of the patient as well as pulmonary aeration. She was treated with Bennett therapy and as much ambulation as she could tolerate. Despite these measures, the patient had rales and rhonchi in the chest, and developed postoperative pneumonia.

On the fourth postoperative day, the patient had moderately hyperactive bowel sounds and passed flatus. Early on the seventh post-operative day, there was a complete evisceration of the wound. The patient was rushed to the operating room where through and through closure of the wound with wire sutures was performed. The patient tolerated this procedure relatively well. On the fourth day following the dehiscence repair, the hemoglobin was 8.6 gm, and the patient was given another unit of blood. She seemed to be improving slowly, and by the twelfth postoperative day the wire sutures were removed and the patient was scheduled to be sent home.

On the morning of June 13, 1964, a radical change was noted in her condition. She exhibited Cheyne-Stokes respirations, and her blood pressure was checked at 50/30. She was afebrile and unresponsive. The pulse was 78 and irregular. The medical service was consulted, and observed that the pupils were unequally dilated and there was no reaction to light. There was a right lower facial weakness and the extremities were flaccid. The patient was comatose and unresponsive. The consultant's impression was that the patient was in shock, either as the result of a cerebrovascular accident or of septicemia, despite the fact that the patient had been afebrile for 48 hours. Intravenous Aramine did not succeed in raising the blood pressure, and the patient died quietly.

An autopsy was performed. The final diagnoses were: postoperative status following bilateral oophorectomy for papillary serous cystadenoma of right ovary and teratoma of ovary featuring cystic dermoid elements, thyroid-like tissue, papillary serous cystadenoma and serous cystadenofibroma of left ovary; secondary closure of wound dehiscence; fibrinous peritonitis; pelvic vein phlebothrombosis; bilateral pulmonary artery emboli; acute organizing bronchopneumonia; arterial and arteriolar neprosclerosis with

chronic focal pyelonephritis; chronic cholecystitis and cholelithiasis; generalized arteriosclerosis meningioma; fibrous pleural adhesions; thyroid adenoma; and small infarct of the left globus pallidus. The principal cause of death was thought to be multiple pulmonary artery emboli.

Discussion

Douglas M. Haynes, M.D., professor and chairman, department of Obstetrics and Gynecology, University of Louisville School of Medicine.

This case illustrates several problems that may arise in the management of a large abdominal tumor in an elderly, poor risk patient. The clinical history provided by such a patient is likely to be unreliable; in the present instance, the patient's complete lack of awareness that her abdomen was becoming distended until six days before her admission with an obvious, tremendous intra-abdominal mass must be interpreted as the result of senile mental changes. Certainly, her extreme emaciation, dyspnea, dehydration and unilateral leg swelling must have developed gradually over a period of months. The history of rapid abdominal enlargement always raises the question of the differentiation of encapsulated from free fluid. If the distension is due to ascites, temporary but effective relief can be provided the patient by performing an abdominal paracentesis to drain much of the fluid. This procedure is contraindicated if the fluid is encapsulated, since spillage of intracystic fluid from certain pelvic tumors, notably pseudomucinous cystadenomas of the ovary, may result in implantation of viable tumor cells on the peritoneal surfaces in cases otherwise potentially operable for cure. Free and encapsulated fluid can readily be differentiated from one another by percussion of the abdomen while the patient lies on her back. If free fluid is present, the gas-filled bowel loops float anteriorly, giving a tympanitic percussion note, while dullness is encountered in both flanks where the ascitic fluid accumulates under the influence of gravity. If the fluid is confined within the capsule of a cystic tumor, exactly opposite findings are noted; the tense cyst rides anteriorly and is dull to percussion, while the intestines are displaced laterally into the flanks, producing tympany there. The latter finding was present in the case under discussion, and this, coupled with the absence of a fluid wave and the impression of a cystic mass filling the pelvis gained by pelvic examination, established the working diagnosis of a large encapsulated tumor, although ovarian carcinomatosis could not be ruled out.

Even though the patient was clearly a poor candidate for major operative attack, it was the consultant's opinion in this case that she deserved a laparotomy to establish a correct diagnosis. Even when carcinomatosis with seeding of the peritoneum proves to be present, surgical removal of as much tumor tissue as possible constitutes worth-while palliation, since it slows the rate of recurrence of the distressing massive ascites found in such cases. In the event that a massive encapsulated tumor is benign or shows malignant changes confined to the ovary, extirpation for cure may be possible. In this patient, the large tumor proved to be a papillary serous cystadenoma which had not extended beyond the capsule and was removable intact. Although these tumors are potentially malignant in their behavior even when they appear histologically well differentiated, some patients have been cured following their removal. The second tumor, a cystic teratoma, was clearly benign.

The definitive operation indicated in potentially malignant ovarian tumors consists of total hysterectomy and bilateral salpingo-oophorectomy. This was the procedure that was planned in this patient, but an alarming hypotension which developed immediately following removal of the adnexal tumor masses motivated the operator to close the abdomen without removing the uterus. While failure to complete the minimum curative operation was a regrettable deficiency, in this instance subsequent events confirmed the surgeon's estimate of the precariousness of this aged patient's condition.

The postoperative complications encountered in this case illustrate the serious hazards of major surgical attack on geriatric patients in poor general condition. The difficulties encountered in securing adequate pulmonary ventilation and ambulation led, respectively, to postoperative pneumonia and pulmonary embolism, and the latter proved fatal. The patient's emaciated and anemic condition undoubtedly pre-disposed to the infection which preceded the dehiscence of the wound. Her circulatory instability led further to a cerebrovascular accident which, in turn, must have aggravated the acute bronchopneumonia. Although in retrospect it is clear that this patient's death resulted from complications arising directly from the operation to remove the large ovarian cyst, in view of her debilitated condition her prognosis would also have been poor if no such attempt had been made. Potentially curable surgical lesions should be removed whenever reasonably possible, but the decision of when to operate sometimes taxes the surgeon's clinical acumen, particularly in the geriatric age group in which the patient's ability to withstand an operation is often extremely difficult to evaluate.

Attend the President's Luncheon at the KMA Annual Meeting, 11:50 A.M. September 22.

SPECIAL ARTICLES

Management of Newly Found Positive Tuberculin Reactor

J. Ray Bryant, M.D.

School Age Tuberculin Reactor

THE skin test should be repeated if there is less than 10 mm. induration with intermediate strength PPD. The test need not be repeated if the area of induration is greater than 10 mm. Where multiple puncture technique is positive, an intermediate PPD should be done in all cases regardless of the size of the induration.

Management of the Reactor Child

X-ray of Chest: If a lesion is seen then three fasting gastric washings should be obtained for culture for tubercle bacilli if this is possible. The child should then be started on treatment with INAH in the amount of 15 mgm/kilo but the total dose should not exceed 300 mgm/day. PAS should also be given in the amount of 300 mgm/kilo up to a maximum dose of 12 gm./day. This treatment should be given for a minimum of one year. It is not necessary to isolate the the child or stop him from going to school unless a cavitary lesion can be demonstrated.

If the x-ray is negative, it should be repeated at yearly intervals. If the child is over 12 years of age and the skin test is positive to the extent of more than 15 mm. of induration, the x-ray should be done every six months until age 20.

If the child is known to be a recent converter (within the last one year) and no x-ray lesion, he should be treated as above with INAH alone. Since children with 20 mm. or more of induration are usually close contacts of an active case, these children should receive INAH prophylactically as above.

If a child with a known positive tuberculin test for any reason is given adrenal corticosteroid therapy for two weeks or longer or develops measles, he should be treated as above with INAH for a minimum of two months after recovery from measles or cessation of steroids. If the x-ray is still negative at that time, treatment may be stopped.

Management of Family Contacts

All family contacts should be skin tested. If an active case of tuberculosis is found among the contacts, this patient should be referred to the local Health Department. If the skin test is positive and the x-ray negative, management is the same as in paragraphs two and three of 'Management of the Reactor Child', above.

Children with positive skin tests under school age should be treated immediately with INAH in the amount of 15 mgm/kilo for a total of one year.

Safeguards in X-Ray Procedures†

"NINETY-TWO per cent of the x-ray machines surveyed in Jefferson County in January and February, 1965, now meet *every guide* for such equipment as listed in the Radiological Health regulations of the Kentucky State Department of Health. This indicates that 71 per cent of the machines that needed some corrections two months ago have now met all provisions of the regulations," said F. Wesley Wilcox, director of Radiological Health, Kentucky State Department of Health.

In April 1965, Luther L. Terry, M.D., surgeon general of the United States, appointed an expert advisory committee on x-rays in the health profession. The committee was appointed to help the U.S. Public Health Service Division of Radiological Health promote more effective use of x-rays so that Americans will receive constantly expanding benefits for each unit of x-ray exposure received. Strong consideration will be given to advise on ways research may be used to improve the x-ray machines, as well as to procedures for using them.

Doctor Terry commented, "Our expanding popula-

(Continued on Page 538)

† *Release from the Kentucky State Department of Health.*

EDITORIALS

Another Angle

DURING the past spring there has been an unusually heavy toll of life, casualty, and property loss throughout the midwest from natural disasters due to floods, tornados, and fire. This points up anew the physicians' obligation in community planning for mass disaster. Our efforts in this regard have been directed largely toward the anticipation of casualties from war or invasion; we tend to forget that destruction of life and property on a large scale proceeds inevitably during peace time. Unfortunately, we continue to remain unprepared to meet this challenge which may unexpectedly strike our own community at anytime.

The average physician assumes grave responsibility 24 hours a day for medical care of patients in his office, the hospital and home. There remains little time or disposition for organization to mobilize for mass disaster. To be able to bring the best qualified medical attention to injured persons at any unspecified time and place is our problem; our preparation for this is generally somewhat lacking.

The hospital facilities in both large and small communities are constantly overcrowded. To care for 200 seriously injured in one disaster would be an almost insurmountable task for the hospitals in any of our cities without a well organized and prepared plan, and the injury of ten in the smaller communities would usually tax the facilities beyond their capacity. In Indianapolis on October 31, 1963, there occurred an explosion and fire at the Indiana State Fairgrounds Coliseum costing 80 lives and approximately 500 injured. The hospitals in that community were not prepared and the organization of the medical and ancillary professions who care for the injured was less than adequate. To a greater or less degree there has been a repetition of similar tragedies throughout the country.

Most of our hospitals have prepared a disaster plan for the mobilization of physicians, nurses and technicians for such emergency service. It is most difficult, however, to keep the organization in continuous readiness. The preparation for traffic control, ambulance service and communication has been still less well planned.

Resuscitation for the severely injured is often the most urgent immediate problem. Our anesthesiologists are best trained in this technique and are usually available at the larger hospitals for emergency service. The physician, however, in whatever field he may practice, is poorly trained in the techniques of resuscitation. Periods of instruction and equipment with the simple instruments necessary for this technique could be accomplished with the expenditure of a reasonable amount of time and effort. The treatment of shock, blood loss and burn should likewise be a part of every physician's emergency training. The instruction in medical schools is not adequate. The physician in daily practice has a responsibility to have a working knowledge of these methods. The splinting and preparation for transportation of the severely injured patient could well be included in such a course of preparation.

Doctor William T. Rumage, Jr., is conference chairman for the A.M.A. Committee on Disaster Medical Care and chairman of the similar KMA committee, and during the past few years he and his committee have done creditable work in Louisville and throughout the state in an effort to train physicians in mass emergency procedures. They have received somewhat less than enthusiastic cooperation from the profession. It would be to our credit as physicians if we were willing to assume a more active and continuous participation in training of all members for catastrophies. Explosions, flood, cyclone, and fire are no respectors of persons or places. We cannot foresee when our own community will be the victim. It is well that we be prepared.

SAM A. OVERSTREET, M.D.

Statesmanship

A KENTUCKY surgeon, long concerned with post-operative rehabilitation, was recently able to make a significant contribution to medical legislation. Having studied HR 6675 (the House Committee version of Medicare) he found a provision which would have allowed industrial injury patients to receive, in effect, double coverage. In many cases the benefits proposed would have made continued disability more profitable to the accident patient than returning to work. While the Senate Finance Committee was hearing testimony on HR 6675, the surgeon consulted Senator John Sherman Cooper in Washington. Senator Cooper is not on the Finance Committee, but, after learning the disadvantages of the proposed legislation, telephone the information to Senator Byrd, Chairman of the Senate Finance Committee. Senator Byrd expressed concern, and scheduled the Kentucky surgeon to testify before the Committee on the following day.

On the following morning, Senator Cooper introduced the surgeon to the Senate Finance Committee. Through the help of the AMA Washington office, he was able to supplement his oral testimony with a written summary. The Committee has voted to eliminate from the bill the incentive to patients to delay recovery.

This accomplishment emphasizes some of the basic points that have been brought out by KEMPAC and our other authorities on legislative affairs. Our elected representatives prefer not to pass bad legislation. Those who would influence them should thoroughly understand the subject, and be able to present their information in a cogent and specific manner.

No, this did not defeat Medicare. It did make Medicare less bad. It did present to the legislators a better impression of the sincerity of the profession than would a dozen emotional outbursts against "Socialized Medicine."

GEORGE F. BROCKMAN, M.D.

In Recognition

J. P. SANFORD, for 15 years executive secretary of KMA and managing editor of The Journal, was named president-elect of the Medical Society Executives Association during the AMA Annual Meeting in New York just prior to the deadline for this issue.

While modesty might have prevented his announcement of this most recent achievement, the editors are taking advantage of his absence to recognize Mr. Sanford for the honor given him by his peers.

He is also a member of the Board of Directors of the State Medical Journal Advertising Bureau, Inc., and has made many contributions in other important para-medical fields.

The editors congratulate Mr. Sanford on his new office, which we are sure he will fulfill with the same efficiency with which he undertakes any job.

THE EDITORS

ORGANIZATION SECTION

Sixteen Outstanding Guest Speakers to Appear on Scientific Program Of 1965 KMA Annual Meeting September 21-23 in Louisville

An important program of postgraduate scientific education will be offered to the physicians of Kentucky September 21-23 when KMA holds its 1965 Annual Meeting at the Convention Center in Louisville.

Delmas M. Clardy, M.D., Hopkinsville, president of the Association and chairman of the Council on Scientific Assembly, in releasing additional information on the meeting, said that sixteen excellent guest speakers, representing various medical specialty fields, will take part in the scientific sessions in individual or panel presentations.

An improved program format, allowing specialty group meetings to be held without conflict with the general sessions, has been arranged, Doctor Clardy said.

Philip M. Crane, Ph.D., assistant professor of history at Bradley University, will be the featured speaker at the President's Luncheon on Wednesday, September 22, at the Kentucky Hotel.

Doctor Clardy released background information on the following guest lecturers:

Arthur C. Curtis, M.D., who will be the guest of the Kentucky Dermatological Society, is professor and chairman of the department of dermatology at the University of Michigan Medical School.

Doctor Curtis will speak at the general scientific session on Thursday morning, September 23, and to his host group that afternoon. His topics have not yet been announced.

He is a member of a number of medical organizations, and has held offices in several, including past presidencies in the Society for Investigative Dermatology, the American Academy of Dermatology and Syphilology, the AMA Section on Dermatology, and others.

Alan A. McLean, M.D., psychiatric consultant for the International Business Machines Corporation, will be the guest of the Kentucky Industrial Medical Association, and will address his host group on "The Emotional Climate of the Company" at the group's Tuesday afternoon meeting, September 21.

"Your Psychiatric Patient at Work" will be his topic at the Wednesday morning general scientific session. Doctor McLean is a fellow of the American Psychiatric Association and chairman of its Committee on Occupational Psychiatry. He is also a fellow of the Industrial Medical Association and a member of the Academy of Occupational Medicine. He is a graduate of the Long Island College of Medicine.

Hurley L. Motley, M.D., professor of medicine and director of the cardio-respiratory laboratory at the University of Southern California School of Medicine, will participate in the Annual Meeting as the guest of the Kentucky Chapter of the American College of Chest Physicians.

Doctor Motley will take part in a panel discussion entitled "Respiratory Distress in the Newborn" at the Tuesday morning general session. That afternoon he will speak before his host group on a subject not yet announced. A former faculty member at Jefferson Medical College and the University of Missouri, he is a fellow of the American College of Chest Physicians and the American College of Physicians, and a member of several other organizations.

H. W. Scott, M.D., who will be the guest of the Kentucky Chapter of the American College of Surgeons, is professor and chairman of the department of surgery at Vanderbilt University School of Medicine.

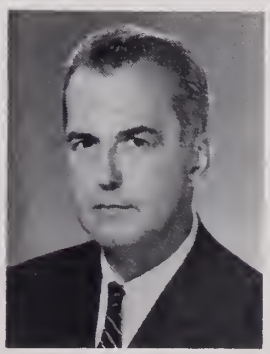
Doctor Scott will participate Thursday morning in the general session in a panel discussion entitled



Doctor Curtis



Doctor Motley



Doctor Scott



Doctor McLean

"Peptic Ulcer". His topic for the meeting of his host group that afternoon has not been selected.

A former medical school staff member at Johns Hopkins University, Doctor Scott is now surgeon-in-chief at Vanderbilt University Hospital. He is a member of a number of medical groups, including the American Association for Thoracic Surgery, the ACS, and the American Gastroenterological Association. He is a past president of the Society of University Surgeons.

A complete list of speakers, as well as the Annual Meeting program, will be published in the August issue of The Journal.

Medicine and Religion Program Planned by Sixth District

A medicine and religion program, the first of its kind planned by a KMA trustee district, will be held by the Sixth Trustee District at its meeting July 13 in Bowling Green, according to Rex E. Hayes, M.D., Glasgow, trustee for that district.

Each member has been asked to bring his minister to this unusual dinner meeting, Doctor Hayes said. Mr. Arne E. Larson, assistant director of the AMA Department of Medicine and Religion, will be the featured speaker on a program designed to further the relationship between medicine and religion.

Harold Keen, M.D., Bowling Green, a member of the KMA Committee on Medicine and Religion, was in charge of arrangements. Working with Doctor Keen are Carlisle V. Dodson, M.D., Russellville, president of the trustee district society, and Paul J. Parks, M.D., Bowling Green secretary.

The meeting will begin at 7:00 p.m. at the Western Hills Restaurant, Doctor Hayes announced.

KMA Announces New Members

The Kentucky Medical Association membership department has announced the addition of nine new members. They include Barbara Bates, M.D. and Bryan P. Geoghegan, M.D., both of Lexington.

Others, all from Louisville, are Henry C. Cassini, M.D., K. A. Hafendorfer, M.D., Robert M. Izard, M.D., and Walter Badenhausen, M.D. Also included are Chris S. Jackson, Jr., M.D., Danville; W. T. Hill, M.D., Russellville; and L. E. Martin, M.D., Adairville.

Physicians Honor Dr. Miller

Oscar O. Miller, M.D., a past president of KMA and the Jefferson County Medical Society, received the University of Louisville Hospitals Alumni Association's distinguished alumnus award at the group's annual meeting June 3 at Stouffer's in Louisville.

Doctor Miller, now 80, has been a member of the U. of L. Board of Trustees for fifteen years and was medical director at Waverly Hills Sanatorium and Hazelwood Tuberculosis Hospital. He is an emeritus professor of medicine at the University.

Dr. Coe Elected President of Ky. Heart Association

Walter S. Coe, M.D., Louisville, was elected president of the Kentucky Heart Association June 10 at the KHA annual meeting in Louisville. Doctor Coe succeeded William R. Bushong, M.D., Tompkinsville, in office.



Doctor Coe

Doctor Coe is associate editor of The Journal of the Kentucky Medical Association and associate clinical professor of medicine at the University of Louisville School of Medicine. He is president of the Kentucky Society of Internal Medicine and former president of the Louisville and Jefferson County Heart Association.

A former director of the Kentucky Heart Association, Doctor Coe has also served as president of the University of Louisville Medical Alumni Association. He is a 1943 graduate of the medical school.

Other physicians elected to office at the same meeting are E. D. Pellegrino, M.D., Lexington, first vice-president; George W. Pedigo, Jr., M.D., Louisville, vice-president; and Morris M. Weiss, Jr., M.D., Louisville, named to the board of directors.

A digest of the actions of the AMA House of Delegates at the 1965 Annual Meeting in New York June 20-24, and a list of all Kentucky physicians attending this meeting, will appear in the August issue of The Journal. Because the AMA meeting was held at the deadline of this issue we were unable to have a full report.

Ky. Pharmacy Board Secretary, E. M. Josey, Dies June 17

E. M. Josey, secretary of the Kentucky Board of Pharmacy and executive secretary of the Kentucky Pharmaceutical Association died suddenly June 17 while enroute to Louisville to a meeting of the KMA Committee on Disaster Medical Care at the KMA Headquarters office.

Mr. Josey was stricken with a heart attack in his automobile on the highway near Frankfort.

He was the originator of the idea and principal organizer of the Allied Council on Medical Services in 1952. He worked with the KMA on many occasions, including the enactment of the Indigent Care legislation in 1960 and other matters of community interest.

Mr. Josey was widely known as an effective lobbyist and as first chairman of the Kentucky Tuberculosis Commission.

Glaucoma Clinic Set for Fair

The fourth annual Glaucoma Clinic will be a feature of the Health-O-Drama at the 1965 Kentucky State Fair September 10-18 in Louisville. The Kentucky Society for the Prevention of Blindness sponsors the annual free glaucoma screening program.

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See white section, P.D.R.

Student AMA

U. of K. SAMA Elects Officers; Reports on Year's Activities

G. T. McMurry, our delegate at the National SAMA convention in Chicago in May, presented a resolution on the floor of the House of Delegates regarding board certification in Family Practice. Several other resolutions were also presented and the House adopted a combined resolution as prepared by the Committee on Medical Education.

Our new officers for next year are: Philip K. Blevins, president; Martin L. Wheeler, vice-president; James R. Harrod, secretary; and Raymond G. Jacobsen, treasurer.

Year-End Report

(The following is a condensed version of the year-end report as prepared by outgoing president Moore)

Present membership is 205 out of a total student population of 260. The membership committee report included contacts made last summer with new students, and the "buddy" system carried on throughout the year, an arrangement that will be continued and expanded this year.

The publicity committee began publication of a Newsletter in the fall of 1964, which was issued five times during the year.

Robert Long, M.D., Louisville, a member of the AMA Board of Trustees, presented an open forum on "Federal Aid to Medical Care". Other programs were presented by U. of K. Medical Center staff members.

The Nominating Committee met to draw up the slate of officers, and the constitution committee drew up and adopted a constitution for the Chapter.

The recently formed Appalachia Committee has as its purpose a plan for the participation of medical students in the Appalachian volunteer program, whereby students will take scientific demonstrations to Eastern Kentucky.

The Chapter has been represented at the SAMA President's conference, the 1963 Spring Regional meeting, and the National meeting, as well as the Annual and Interim meetings of the Kentucky Medical Association.

SHIRLEY M. MOORE
President (U. of K.)
SAMA Chapter

U. of L. Representative Reports On National SAMA Convention

James Z. Appel, M.D., Lancaster, Pa., president of the AMA (then president-elect) and Walter Alvarez, M.D., Chicago, were among the featured guest speakers at the May 2-6 national convention of the Student American Medical Association, according to a report by James R. Ramey, delegate from the U. of L. SAMA chapter.

Mr. Ramey's report of the meeting, which was received too late for the June issue of The Journal, included information on the election of James P. Moss, also of U. of L., as president of the organization. A story on the election was carried in the June Journal.

Scientific sessions, meetings of the House of Delegates, and special sessions, including a breakfast sponsored by the American Medical Political Action Committee, highlighted the four-day meeting.

Among the resolutions adopted by the House were three concerning the acceptance of physicians solely according to ability, character and judgement, reporting the "Battered Child Syndrome", and increasing financial aid to medical students. SAMA will hold its 1966 meeting in Los Angeles May 12-15.

Substantial Ad Contract Given Journal by Drug Company

As our Journal better serves its readers, more advertisers will seek to use our publication to make their products known to our members.

The Journal is therefore proud to announce that Lakeside Laboratories has chosen our Journal for the inclusion of nine advertising pages each month for the next six months.

Your editors feel that the service rendered our membership by our advertisers is twofold. First, through revenue received from our advertising columns we are able to pay a substantial portion of the costs of publication in the promotion of continuing education. Second, we are able to present the latest products and services, which are so important to our members.

Your editors urge you to read and support, within the best interests of your patients, our carefully selected advertisers.

Second Ky. TB Conference Set

November 4, 5, and 6 are the dates for the second Kentucky Conference on Tuberculosis, to be held at the Campbell House in Lexington, according to T. A. Sanford, Lexington, conference chairman.

The purpose of the conference is to reassess the recommendations for the eradication of TB as outlined at the first conference in 1961, and will up-date and add to these recommendations. A number of physicians will participate in the program.

Dr. Stacey Named Special Advisor

Adam Stacey, Jr., M.D., Pineville, has been named by Governor Edward T. Breathitt as his special advisor on the Appalachian Development Act's medical program.

The act provides $41 million in the 11-state area for hospitals, health facilities and regional diagnostic and treatment centers. Doctor Stacey is a 1932 graduate of the University of Louisville School of Medicine and a veteran of World War II. He is a general practitioner.

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in common
anorectal disorders

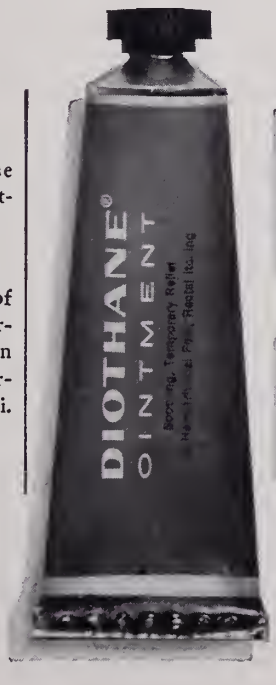
"non-caine"
Diothane®

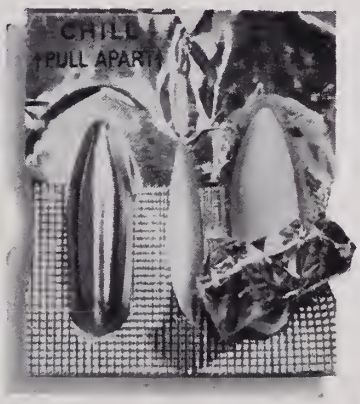
Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

DIOTHANE OINTMENT

COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

Merrell

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KENTUCKIANS IN WASHINGTON to attend the workshop conference of the American Medical Political Action Committee in May were, seated: Mrs. Hoyt D. Gardner, Louisville; Delmas M. Clardy, M.D., Hopkinsville; Harold B. Barton, M.D., Corbin; and Mrs. Arthur Holmes, Covington. Standing, from left, are: Richard F. Greathouse, M.D., Louisville; Carl Cooper Jr., M.D., Bedford; C. K. Dixon, Jr., M.D., Jeffersontown;. J. P. Sanford, Louisville; Daryl P. Harvey, M.D., Glasgow; Hoyt D. Gardner, M.D., Louisville; C. Melvin Bernhard, M.D., Louisville; G. L. Armstrong, Louisville; William M. Wyatt, M.D., Somerset; and Everett H. Baker, M.D., Louisville.

Ky. M.D.s Represented at AMPAC Washington Workshop

Fourteen Kentuckians were among the more than 300 physicians, their wives, and medical association representatives attending the American Medical Political Action Workshop in Washington, D.C., May 22 and 23.

Harold B. Barton, M.D., Corbin, chairman of the Board of Directors of KEMPAC (Kentucky Educational Medical Political Action Committee) and Richard F. Greathouse, M.D., Louisville, KEMPAC secretary, led the Kentucky delegation.

Also attending were KMA president Delmas M. Clardy, M.D., Hopkinsville; Everett H. Baker, M.D., Louisville, president-elect; and Hoyt D. Gardner, M.D., Louisville, AMPAC Board member; with other officers, legislative key men, and staff members of KMA. (See picture this page)

Doctor Gardner conducted one workshop session and at the Saturday night dinner presented Blair Henningsgaard, M.D., Astoria, Ore., with a silver cup commemorating his participation in the KEMPAC dinner meeting last September. The cup is presented each year to the AMPAC Board member who appears on the program.

Donovan A. Ward, M.D., Dubuque, Iowa, AMA president, made the keynote address of the meeting. Sharing the program with Doctor Ward were four U.S. representatives and two senators, Everett M. Dirkson of Illinois and S. L. Holland of Florida.

Dr. Chatham Honored

Donald Chatham, M.D., Shelbyville, was awarded a plaque in recognition as an outstanding alumnus of Georgetown College at the annual meeting of the school's alumni association May 27 at Georgetown.

Doctor Chatham, vice-chairman of the KMA Board of Trustees, has served two terms as president of the Georgetown Alumni Association. He graduated from the college in 1948 and received his medical degree from the University of Louisville in 1952.

AMA to Sponsor Conference On Medical Aspects of Sports

The Seventh National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of the AMA Committee on the Medical Aspects of Sports, will be held in Philadelphia at the Benjamin Franklin Hotel on November 28.

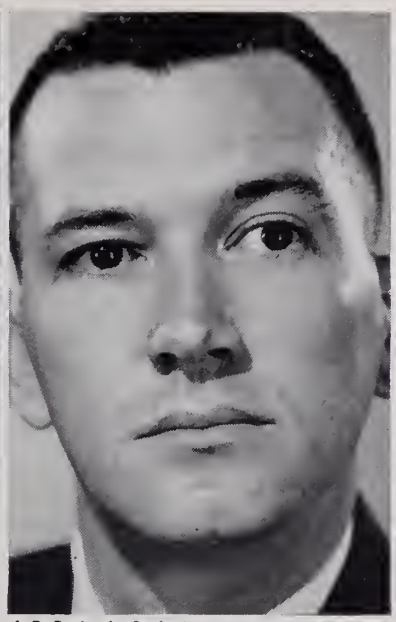
The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the AMA. In addition, the Conference will be held in cooperation with the observance of the bicentennial anniversary of the University of Pennsylvania's School of Medicine and of medical education in the United States.

As was true of the previous six Conferences, the Seventh will cover a wide range of subjects of interest to physicians, especially those serving school and college sports programs. Included will be papers, panels and discussions relating to readiness for sports participation, management of health problems in sports, and application of research to injury prevention.

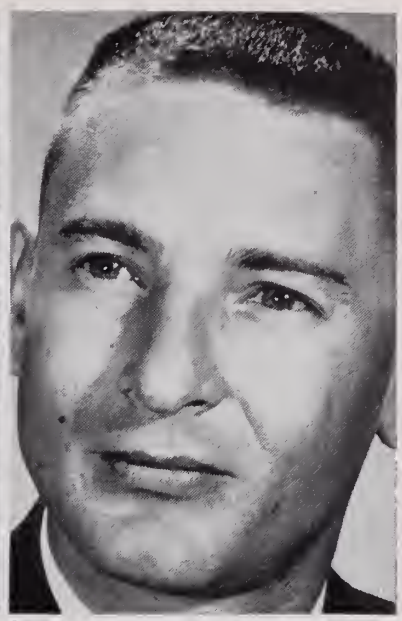
Those interested in receiving further information concerning the conference should address the Secretary, Committee on the Medical Aspects of Sports, AMA, 535 North Dearborn St., Chicago, Ill., 60610.



H. J. Brown—Owensboro-Paducah



J. B. Darland—Covington



R. A. Schehr—Louisville

"We're puzzled"*...

...why some physicians use synthetic preparations or thyroglobulin

...why some use nonbrand thyroids or write "thyroid U.S.P."

...when ARMOUR THYROID offers so many more advantages

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NEW—for a continuous supply of Armour Thyroid for you or your immediate family simply complete and return this coupon

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Please circle potency requested.

MEDICAL SCHOOL NEWS

U. of L. Announces $491,920 In Med School Grants

The Board of Trustees of the University of Louisville at its June 16 meeting accepted a total of $491,920 in gifts and grants to be used for various purposes within the School of Medicine.

Individual grants were made to the following: William K. Keller, M.D., $110,323 for training graduate physicians in psychiatry, and $45,368 for undergraduate training; $80,202 to Peter K. Knoefel, M.D. as a training grant for the Ph.D. program in Pharmacology; $56,590 to Leonard B. Berman, M.D., for a training grant in renal medicine; and $51,138 to Ephraim Roseman, M.D., for resident training in neurology.

William A. Brodsky, M.D., $43,928 for a training grant in physiology, and $23,205 as a renewal for research in the phenomena of transport of materials across living membranes; $20,000 to J. T. Ling, M.D. for operations in the Radiation Center; $15,216 to Duncan Dallam, Ph.D., for the investigation of enzyme systems; $12,552 to Joseph F. Gennaro, Jr., Ph.D., for his research on coral snake venom; and $12,370 to Paul B. Johnston, Ph.D., for his studies of viruses.

In other gifts and grants, the trustees accepted $5,000 from Ross Laboratories for the department of pediatrics; $1,050 from the Louisville TB Association for the pulmonary disease center; and $1,000 from the estate of Ira V. Grissim, M.D. for the medical school.

Staff Appointments and Changes

The Board accepted the change in status of C. Dwight Townes, M.D. who has stepped down as head of the department of ophthalmology to remain as a full professor of ophthalmology. Roderick Macdonald, Jr., M.D., was named acting chairman of the department.

Woodford B. Troutman, M.D., was named clinical professor emeritus of medicine. The trustees also accepted the following appointments in the department of medicine:

Marcine C. Davies, M.D., to assistant professor; William C. Gaventa, M.D., assistant clinical professor; Col. Robert J. Hoagland as clinical professor; Paul C. Grider, M.D., clinical instructor; Norman Glazer, M.D., clinical instructor; and Nestor J. Carlisky, M.D., instructor.

In the department of pediatrics, the following changes were approved: Donald R. Kmetz, M.D., associate in pediatrics and assistant professor of pathology; Duncan R. McMillan, M.D., assistant professor of pediatrics.

Walker Mc. Wolfe, M.D., was named assistant professor of obstetrics and gynecology; and Billy F. Andrews, M.D., was given the additional post of associate in obstetrics and gynecology. He is already assistant professor of pediatrics and associate in microbiology.

Others are Walter L. Broghamer, Jr., M.D., clinical instructor of pathology; Luther Pearce, M.D., instructor in psychiatry; Walter W. Surwillo, Ph.D., associate professor of clinical psychology; and Harold W. Conran, M.D., assistant clinical professor of psychiatry; and Howard E. Ganther, Ph.D., assistant professor of biochemistry.

The Board of Trustees also accepted the resignations of Luis Spamer, M.D., as assistant professor of physical medicine and rehabilitation; Daniel Stowens, M.D., as associate professor of pathology; and James A. Kennedy, Ph.D., as professor of microbiology.

AMA Reports on New Licenses Issued to Physicians

A total of 7,911 physicians were newly added to the licensed medical profession in the U.S. in 1964, according to a report by the AMA Council on Medical Education appearing in the June 7 issue of The Journal of the American Medical Association.

The report goes on to state that a total of 17,885 licenses to practice medicine and surgery were issued during 1964 by 55 authorized boards in the U.S. and its territories. This total included first licenses for new physicians, licenses for physicians moving to other states, and licenses for foreign-trained physicians.

Of all licenses issued during 1964, 7,166 were granted after successful written examination and 10,719 by reciprocity and endorsement of state licenses or the certificate of the National Board of Medical Examiners.

As of December 31, 1964, there were 284,271 physicians in the U.S., (excluding 1,740 temporarily in other countries).

McDowell House Featured

An article recognizing the Ephraim McDowell House at Danville as a national historical shrine was published in the May, 1965 issue of The Bulletin of the Woman's Auxiliary to the American Medical Association. The item cited the efforts of the Kentucky Medical Association and its Auxiliary in restoring, furnishing, and supporting the home and apothecary shop as a monument to the pioneer surgeon.

FOR SALE

One **BAUSCH AND LOMB** microscope in perfect condition. A bargain at $150.00.

Dr. H. V. Johnson
Georgetown, Ky.



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



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Three tablespoonfuls (45 cc.) contain:		
Pipradrol hydrochloride		2 mg.
Vitamin B_1 (thiamine hydrochloride)	(10 MDR*)	10 mg.
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Vitamin B_6 (pyridoxine hydrochloride)		1 mg.
Nicotinamide	(5 MDR*)	50 mg.
Choline†		100 mg.
Inositol†		100 mg.
Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
Cobalt (as chloride)		1 mg.
Manganese (as sulfate)		1 mg.
Magnesium (as acetate)		1 mg.
Zinc (as acetate)		1 mg.
Molybdenum (as ammonium molybdate)		1 mg.
Alcohol 15%		

*Multiple of adult Minimum Daily Requirement supplied
†Requirement in human nutrition not yet established

the need for a tonic knows no age

Anyone can feel tired and "old" too soon. In such functional fatigue, Alertonic helps to lift mood, revive interest, restore purposeful activity promptly. Yet it contains no MAO inhibitors, no hormones. Alertonic is the effective formulation of a cerebral stimulant (pipradrol hydrochloride), alcohol, vitamins, and minerals ...available on prescription *only*. For common functional complaints (mild mood depression, tiredness); geriatric or convalescent patients, Rx one *tablespoonful* Alertonic *t.i.d.*, thirty minutes before meals. Contraindicated in agitated pre-psychotic patients, paranoia, or other patients in whom hyperexcitability, anxiety, chorea, or obsessive-compulsive states are present. Mild central stimulant side effects may occasionally occur.

Brochure with full product information available on request.

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Digest of the Minutes of the Board of Trustees' Meeting

June 3, 1965

Current legislative proposals now pending in the Congress occupied the major portion of consideration by members and guests of the Board of Trustees at a special meeting Thursday, June 3, in Louisville.

The meeting was called by the Chairman of the Board, Robert E. Pennington, M.D., London, for the purpose of briefing members of the Board and others on how these proposals, if enacted, might effect the practice of medicine in Kentucky. Between fifty-five and sixty attended.

Mr. Aubrey Gates, Chicago, director of the AMA Field Service and a member of the AMA Legislative Task Force, along with Mr. James Foristel of the AMA Washington Office, who in addition to being a lobbyist is an analyst of legislative proposals, were most effective in presenting and analyzing the issues. Both members and guests expressed gratification in the amount of material covered during the meeting and for the contributions made by the special guests.

It was not anticipated that the Board would take any action on any of these proposals since the meeting was designated as a "think session." However, just before recessing for lunch, guests were temporarily excused and the members of the Board acted on a few matters requiring early attention.

At this time the Board without dissent voted to support the proposed $176,000,000 state bond issue, which will be voted on in the November general election.

"Today's Health Guide" Available

Ralph D. Lynn, M.D., Elkton, chairman of the KMA Public Health Committee, announced the publication of "Today's Health Guide"—the American Medical Association's complete medical guide book for the home and family.

"Today's Health Guide" describes and discusses some 2000 illnesses, diseases and other medical subjects in lay language. Doctor Lynn said, "It's not a 'doctor yourself book', but instead tells your patients when they should seek medical attention." "Today's Health Guide" is available at cost—$4.95. Order from the American Medical Association, 535 N. Dearborn St., Chicago, Ill., 60610.

National Pharmacy Week Set

The week of October 3-9 has been scheduled as National Pharmacy Week by the American Pharmaceutical Association. The traditional theme for Pharmacy Week is "This Week and Every Week Your Pharmacist Works for Better Community Health." In announcing the plans for this year, the APhA encouraged participation by pharmacists in Community Health Week, November 7-13, which is sponsored by the medical profession.

Hygroton®
brand of chlorthalidone

the long-acting diuretic

Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

*Dorhout Mees,E.J.,and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

Photos: A 59-year-old woman with hypertensive cardiovascular disease and edema resistant to low-salt diet and bed rest. The patient lost 8½ lbs. in one week with a single tablet daily of Hygroton, brand of chlorthalidone.

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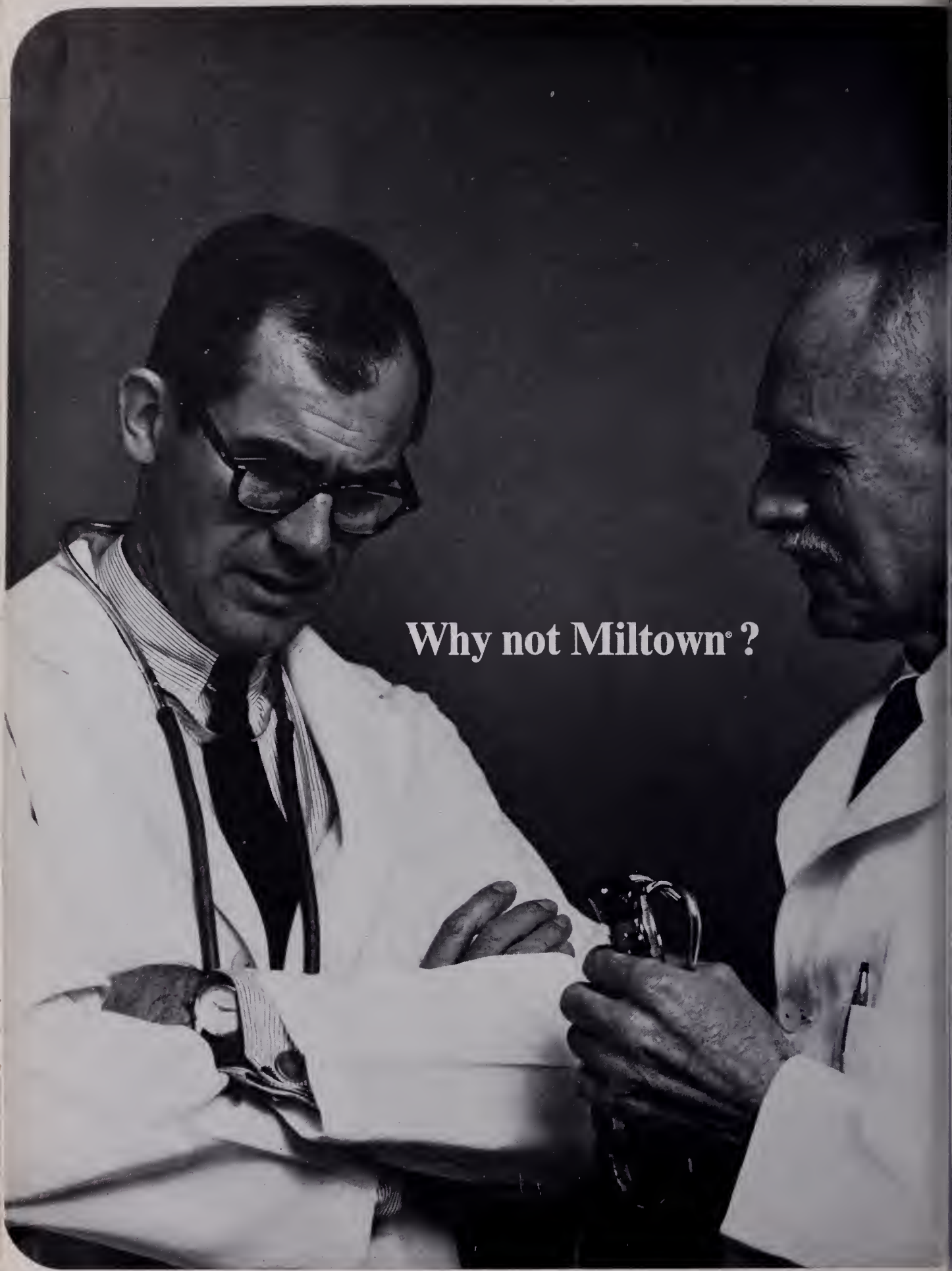


good riddance

Hygroton, brand of chlorthalidone, gets rid of edema efficiently. Your edematous patients will generally need far fewer tablets than with most diuretics. And they'll generally save more on prescription costs. One tablet a day is a popular dosage. So is one tablet every other day. You may even find half a tablet three times a week does the job. No other diuretic works as long. And none has as much natruretic activity per tablet.* For good riddance of edema with the least number of tablets, prescribe Hygroton, brand of chlorthalidone.

Hygroton® brand of chlorthalidone

Geigy


Why not Miltown® ?



There are few "nots" in Miltown therapy

- **Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.**
- **The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.**

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

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After Surgery: B and C vitamins are therapy

Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS, designed to meet increased metabolic demands, aids in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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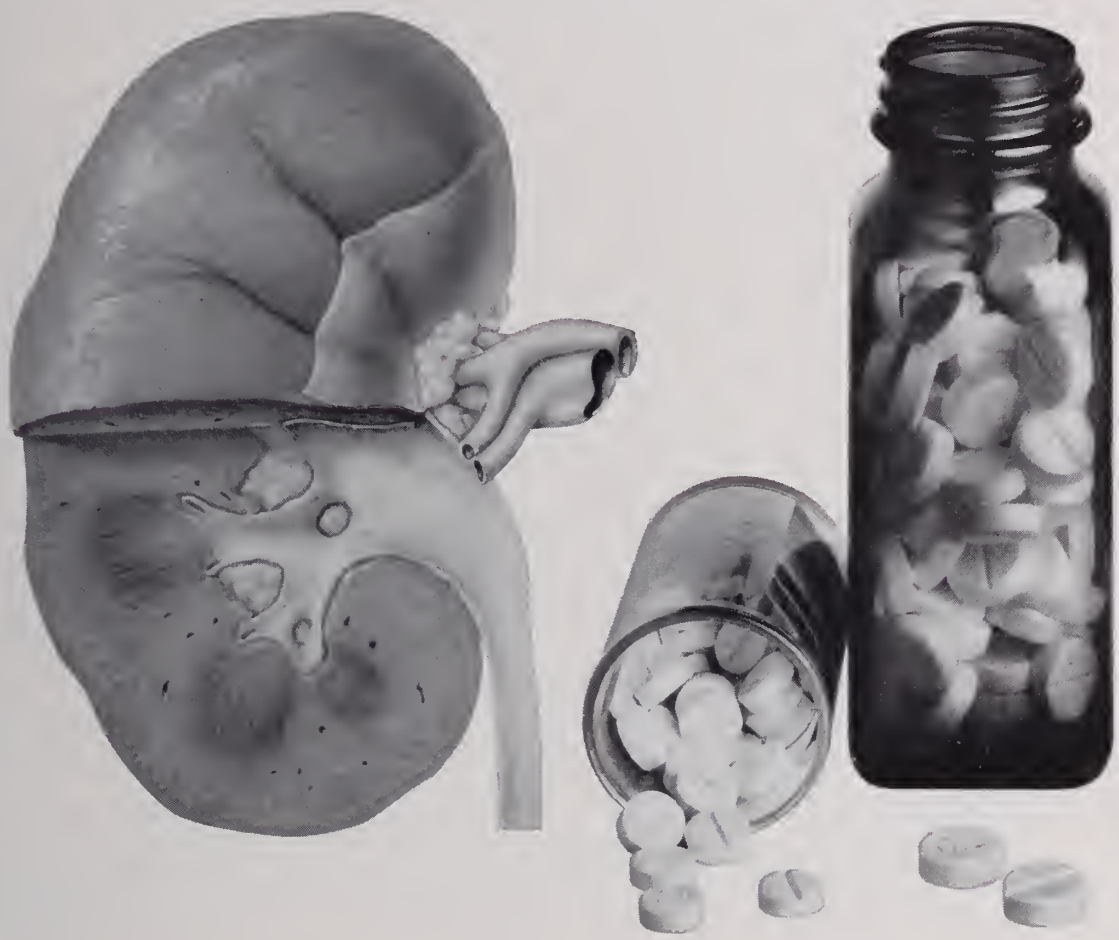
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understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

- Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.
- From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MSD **MERCK SHARP & DOHME** Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

News Items

W. Burford Davis, M.D., Louisville, recently received the Distinguished Alumnus Award from the Centre College Club of Louisville. Doctor Davis, a clinical assistant professor of thoracic surgery at the University of Louisville School of Medicine, is a past national president of the Centre Alumni Association.

Arthur H. Kenney, M.D., ophthalmologist-in-chief at Wills Eye Hospital, Philadelphia, formerly of Louisville, was given a certificate of merit for his contributions to traffic safety in Kentucky, including a medical examination program for drivers. The award was presented by Glenn Lovern, Kentucky Public Safety commissioner, at a luncheon in Louisville in May. Until assuming his present post this spring, Doctor Kenney was chairman of the KMA Highway Safety Committee.

William F. Clarke, M.D., and Mrs. Clarke, of Pikeville, recently entertained Pikeville members of the Pike County Medical Society at a dinner party. Sixteen couples attended the dinner.

Claude E. Cummins, Jr., M.D., Maysville, was honored on his birthday by a "This is Your Life" party given by his fellow choir members at the First Christian Church in Maysville. Doctor Cummins, who has practiced in that city since 1957, is active in church, medical and civic activities.

The alcoholic *CAN* be rehabilitated

With a unique background of 80 years' experience, The Keeley Institute has earned an international reputation as a specialized hospital for the *restorative treatment* of the "problem drinker."

Our progressive, well-rounded regimen includes:

- gradual withdrawal
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Individual and group care are conducted in a friendly, cooperative atmosphere under the direction of physicians and experienced personnel. *We take female as well as male patients.*

Write for detailed, descriptive information on our low cost, comprehensive services—or phone 815 584-3001. We welcome your referrals.

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Dwight, Illinois
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COUNTY SOCIETY REPORTS

Daviess

Fred Reynolds, M.D., Owensboro, took office June 15 as president of the Daviess County Medical Society, it has been announced. Also serving as officers for the coming year are the following: R. J. Phillips, Jr., M.D., vice-president; James H. Callis, M.D., secretary-treasurer; J. H. Kurre, M.D., KMA delegate; and C. E. Lowry, M.D., and Doctor Callis, alternates.

Fayette

At the May meeting of the Fayette County Medical Society the members passed the amendment to the Society By-Laws regarding the required KMA orientation course for new members, and an amendment to exclude from this requirement previous members of the Society and transfer members within the state. The first course will be held in Louisville September 20.

The Society has accepted the following new members: Barbara Bates, M.D., Brian P. Geoghegan, M.D., Theodore N. Guiglia, M.D., Alexander V. W. McBee, M.D., John M. Smith, Jr., M.D., and Keene A. Watson, M.D.

Miss Liza Hancock has accepted the position of executive secretary of the Society.

McCracken

The regular meeting of the McCracken County Medical Society was held May 26 at the Paducah Country Club wigh good representation of local and regional physicians.

Following a steak dinner, the scientific program was presented by Pittman Orr, M.D., and Eli Khouri, M.D., both of Paducah.

The business meeting was called to order at 8:35 by the secretary, Frank B. Crawford, M.D., in the absence of the president and vice-president.

Glenn Noss, M.D., reported that the Public Health Committee had met with H. G. Sargent, M.D., concerning his recent trip to Washington to investigate a possible local Indigent Medical Care program. No action was taken.

Correspondence from KEMPAC was read to the members, reminding them of dues. A letter from KMA President Delmas M. Clardy, M.D., was also read, urging the Society to consider changing its By-Laws to reflect the new membership status provided for in Section 5, Chapter 1 of the KMA By-Laws. This concerns "provisional status" for two years following admission to membership in the Association, during which time the member must complete an orientation course. No action was taken pending receipt of further information concerning the orientation program.

The application of Curtis Bippert, M.D., for membership in the Society was presented to the group. The application was referred to the proper committee for approval and a report will be made to the Society at a later meeting. The meeting adjourned at 9:35 p.m.



one place your hay-fever patient doesn't need **ORNADE**® (unless he has a cold)

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Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

...but if your patient can't get away from hay fever, relieve sneezing, weeping and nasal congestion for 24 hours with one 'Ornade' Spansule® brand sustained release capsule q12h

Summary of contraindications, cautions and side effects: Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction. Use with caution in the presence of hypertension, hyperthyroidism, or coronary artery disease. Drowsiness; excessive dryness of nose, throat or mouth; nervousness or insomnia may occur on rare occasions but are usually mild and transitory.

Before prescribing, see SK&F product Prescribing Information.

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KMA Council and Committee Reports

Hospital Committee

James B. Holloway, M.D., Lexington, Chairman

KMA Headquarters Office **Thursday, May 20, 1965**

Areawide hospital planning occupied the major portion of consideration by members of the Hospital Committee at its meeting on Thursday, May 20, in Louisville. The committee members agreed the Kentucky Medical Association should take the lead in setting up a state-wide area-wide planning group for medical facilities. During the summer, literature will be collected from successful area-planning groups and preliminary discussions will be undertaken with Blue Cross-Blue Shield, Kentucky Chamber of Commerce, and State Government Officials.

Committee members were notified that arrangements have been made for hospitals which wish medical record librarians to come in as consultants to their medical records and to train a medical record librarian. The committee decided that in the future, "dry-run" teams would only inspect those hospitals which had never been accredited or which had lost their accreditation. There will be another meeting of the committe on September 9.

Council on Medical Services

John A. Bishop, M.D., Jeffersontown, Chairman

KMA Headquarters Office **Thursday, June 10, 1965**

The Council on Medical Services met recently to consider the final reports of the nine committees serving under the Council.

Members of the Council reviewed actions of other KMA Councils and committees which were of specific interest to them. The Council also reviewed the actions taken by the AMA Council on Medical Service this past year, including a thorough discussion on the Council's "Report on the Cost of Medical Care".

It is anticipated that the next meeting of the Council will be in the fall to make plans for the 1965-66 Associational year.

Governmental Medical Services Committee

L. F. Beasley, M.D., Franklin, Chairman

KMA Headquarters Office **Thursday, May 27, 1965**

The Governmental Medical Services Committee at their second meeting of the year, had as their guests representatives of the State Department of Health to report on various governmental health programs being conducted in Kentucky.

The Committee met on May 27 at the request of the KMA Board of Trustees to consider maternal and pediatrics clinics and a new governmental program entitled Operation Head Start. Recommendations were made to the Board of Trustees concerning these matters as well as the medical implications in the Appalachian program.

A total of eleven governmental health programs were discussed at the meeting. Members of the committee recommended that a letter be written to the governor of Kentucky requesting more information on some of the programs now in existence.

Tuberculosis Committee

Joseph Humpert, M.D., So. Ft. Mitchell, Chairman

KMA Headquarters Office **Thursday, June 10, 1965**

The KMA Tuberculosis Committee met recently at the Headquarters Office and discussed in great detail the TB testing program in Kentucky and statistics which revealed that the TB problem in this state is still alarming.

It was pointed out that Kentucky ranks seventh highest in the U.S. in cases reported, and second highest in death rate. Arizona is the highest.

The committee received reports from Mr. Thomas Summer, executive director of the Kentucky TB & RD Association; Stuart Lauder, M.D., C. M., director of TB Control, Department of Health, Frankfort; and Mr. Thomas Layton, executive director of the State TB Hospital Commission, Frankfort, on various TB activities with which they are concerned.

A report was given on the Campbell House Conference which will be held in Lexington in November. The theme will be "Theory and Practice in TB Control."



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Mental Health Dept. to Move

The Kentucky Department of Mental Health will move its central offices from Louisville to Frankfort to new quarters in the State Office Building Annex, Governor Edward T. Breathitt has announced.

The move, late this summer, will permit maximum coordination of the mental health and mental retardation programs with education and rehabilitation, health, child welfare, and with such administrative agencies as finance, purchasing, and personnel, the Governor said. These departments are located in Frankfort.

SMA Awards Residency Grants

The Southern Medical Association has announced the award of seven Residency Training Grants under the program established in 1962. This program provides for the award of grants up to $2,400 with no legal obligation to repay funds received. Tax deductible donations, however, made by recipients after training is completed, will increase the number of grants available in the future.

Dr. Teague Appoints Deputy

Russell E. Teague, M.D., commissioner of health for the Commonwealth of Kentucky, recently appointed William S. Wester, Frankfort, as deputy commissioner. Mr. Wester has been executive assistant to Doctor Teague for four years. He is a graduate of the University of Kentucky.

Treatment of Cardiac Failure

(Continued from Page 497)

gardless of the age or the severity of the cardiac failure. Following insertion of the aortic prosthesis, signs of cardiac failure subsided almost immediately. This immediate improvement in cardiac function was considered to be the reason why the five oldest patients (ages 54-63) all survived operation.

These clinical experiences indicate that operative replacement of the aortic valve should be considered in all patients regardless of the refactory state of the cardiac failure if aortic valvular disease is judged to be primarily responsible for cardiac failure.

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In Memoriam

DAVID S. TRAUB, M.D.
Louisville, Ky.
1910-1965

David S. Traub, M.D., 54, an internist and clinical associate in medicine at the University of Louisville School of Medicine, died June 14 at his office in Louisville. Doctor Traub received his medical degree in 1934 from the University of Louisville. He was active in medical and civic affairs in the community.

SAMUEL C. LONG, M.D.
(Formerly) Monterey, Ky.
1869-1965

Samuel C. Long, M.D., 95, who practiced general medicine in the Monterey area of Owen County for more than 50 years, died June 20 at a Frankfort rest home. Doctor Long, who graduated in 1891 from the University of Louisville School of Medicine, had been retired for 25 years.

WALDO R. WILLIAMS, M.D.
Louisville, Ky.
1911-1965

Waldo R. Williams, M.D., 54, chief of surgery at Louisville Red Cross Hospital, died suddenly May 26 following an apparent heart attack. Doctor Williams, a native of Memphis, Tenn., graduated in 1939 from Meharry Medical College, and joined the staff of the Red Cross Hospital in 1944.

Special Article

(Continued from Page 512)

tion, increased life expectancy, more frequent use of medical, dental and hospital resources, and the development of many new radiological procedures have greatly increased the number of x-ray examinations given each year. Because of the immense value of x-rays in health preservation, this trend undoubtedly will continue. However, all radiation exposure is believed to involve risks of some adverse biological effects. From a public health viewpoint this becomes especially significant when very large numbers of people are involved, and the possible genetic effects are considered. Therefore, public health agencies have a responsibility to assist the professional users of x-ray to make the most effective use of x-ray."

In October, 1962, the Kentucky State Department of Health adopted radiological health regulations to assist the professional users of x-ray to make the most effective use of this source of ionizing radiation. At the same time, a provision in these regulations prohibits the use of all fluoroscopic shoe fitting and hand-held fluoroscopic devices. The regulations, written under expert guidance, were primarily based on the recommendations of the Council of State Governments, American Standards Association, and the National Committee on Radiation Protection and Measurements.

To date, the Kentucky Radiological Health staff has performed physical surveys on approximately 1400 of the 3200 x-ray tubeheads registered within the state. As each registrant meets all provisions of the regulations, he effectively reduces x-ray exposure to the patient and operator and thus provides the most benefit per unit of x-ray exposure. The staff expects to complete surveys of all users registered in the state within the next two years.

Tobacco Lab to Get $1.5 Million

A. U.S. House sub-committee recently reported out the agriculture appropriations bill with $1,530,483 to be used by the University of Kentucky tobacco research laboratory.

The money will be used for the following research: smoking and health; improvement of tobacco quality, and related areas; marketing research; and the physical and chemical makeup of tobacco.

Dr. Potter Leaves Harlan

William H. Potter, M.D., president of the Daniel Boone Clinic at Harlan, formerly associated with the UMWA in Harlan, left Harlan July 1 to accept a teaching post at Albert Einstein Medical College in New York.

* * * *

". . . **One of our roving reporters spotted a softball** game being played behind Our Lady of Mercy Hospital Thursday afternoon and a group of Owensboro doctors were opposed by nurses and other staff members from Mercy. No, we didn't get the final score. One of the doctors kept the scorebook and we couldn't find a druggist to read the doggone thing." Herb Parker in the *Owensboro Messenger & Inquirer,* May 28, 1965.

Patients would be safer if we could return to our old symbiotic, give-and take relation with the FDA, and recent activity on the part of its new medical director, Joseph F. Sadusk, Jr., M.D., seems to indicate strongly that there is indeed hope that this may be accomplished.—Editorial in *Pennsylvania Medical Journal,* 68:2, (Feb.) 1965.

The rigid legalistic terms of the 1963 (drug) regulations have alerted legal consultants and administrators in every research organization in the country. Each man reads and has a different interpretation depending on his background. Patient consent for the trial of new drugs is now strongly suggested and is so fraught with ethical, sociological, and educational problems that the clinical pharmacologist must become a master diplomat if he wasn't born this way.—Carl C. Pfeiffer, Ph.D., M.D., in *Journal of New Drugs,* 4:6, (Nov-Dec.) 1964.

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research quiz For two decades, three of these four countries have led the world in drug research. Of the 604 significant drugs discovered in the world during this period, how many do you think came from each country? (Answer above)



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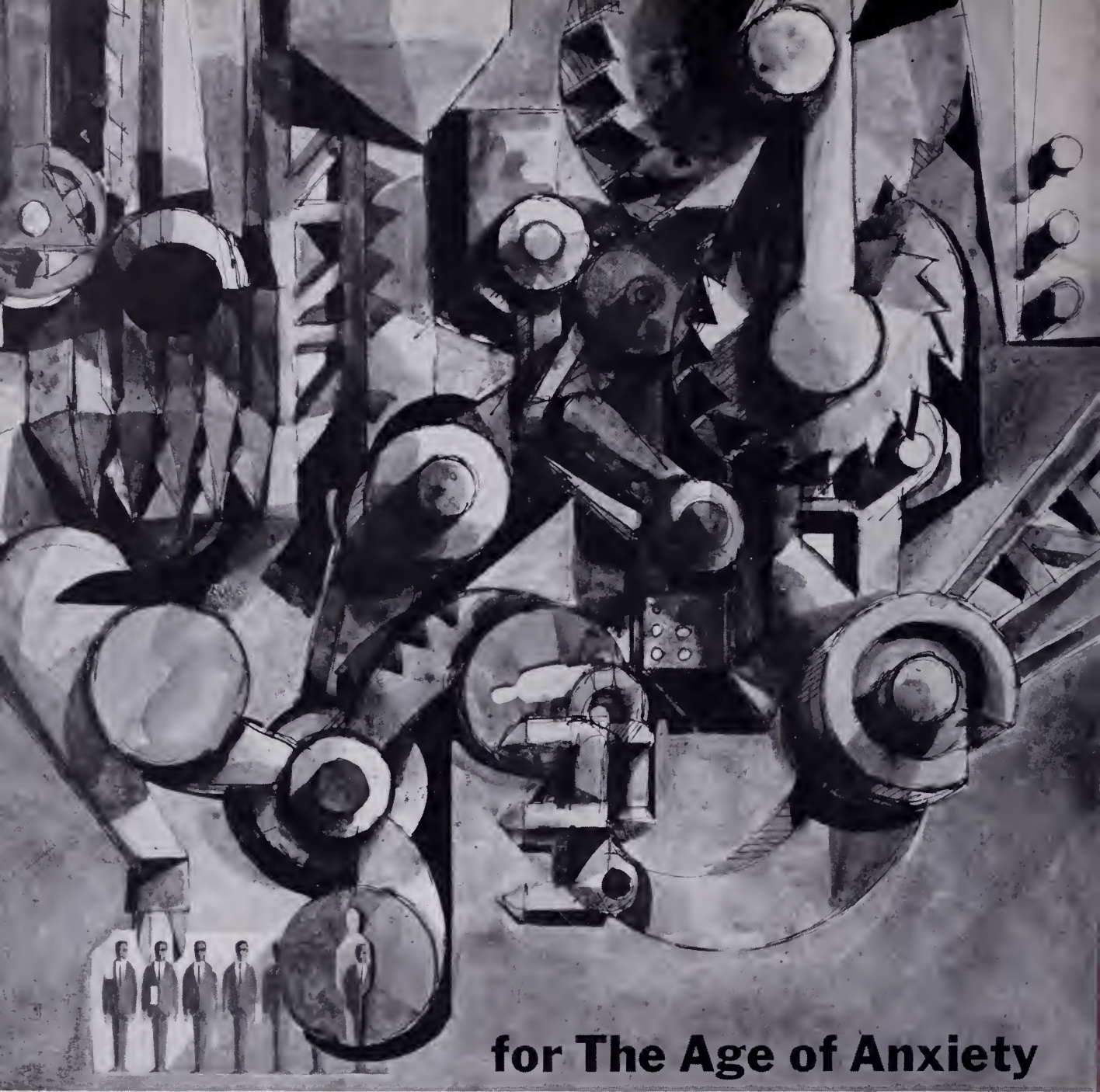
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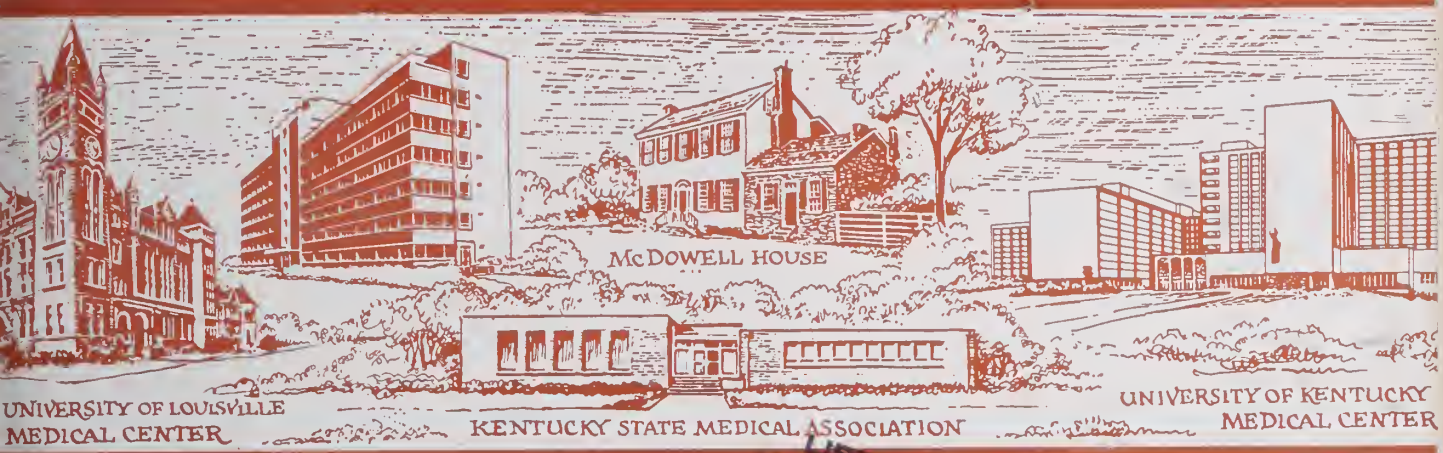
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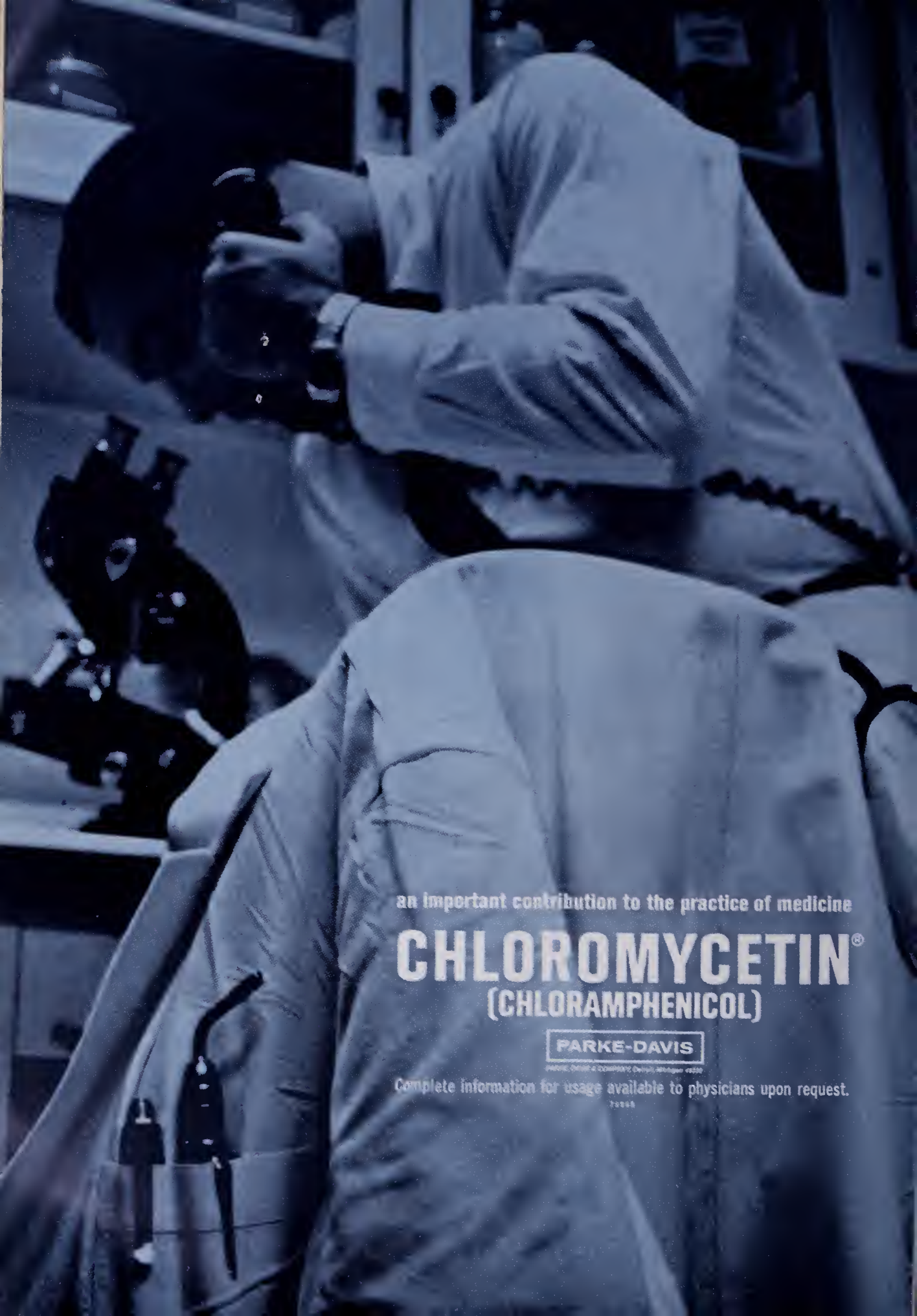
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Thenfadil® HCl 0.1%, a topical antihistamine to help relieve itching.

Zephiran® Cl 1:5000, an antiseptic wetting agent to promote the rapid spread of components to less accessible nasal areas.

NTz is supplied in leakproof, pocket-size, spray bottles of 20 ml. and in bottles of 30 ml. with dropper.

Winthrop Laboratories, New York, N. Y. 10016

NTZ, Neo-Synephrine (brand of phe[illegible]hrine), Thenfadil (brand of thenyldiamine), and Zephiran (brand of benzalkonium, a[illegible]loride, refined), trademarks reg. U.S. Pat. Off.

Hay fever... a summer hazard prescribe NTZ® Nasal Spray



Winthrop

MESSAGE FROM THE PRESIDENT



The Decision is Yours—The Time is Now

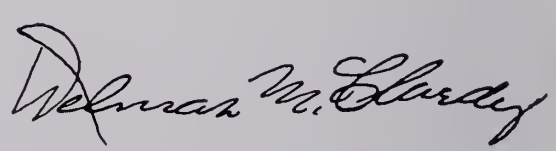
There are times in the life of every individual when he is compelled to make momentous decisions. Once they are firmly made, there can be no turning back. Some hesitate to make such decisions as they eye covetously the comfort of security, the power of wealth, the social prestige that accompanies those who conform, who don't rock the boat, and who don't embrace the controversial issues.

The time is now—for every physician to ask himself if he will or will not enter a scheme of nationalized medicine. "Is life so dear", is comfort so alluring, is economic security so compelling as to be purchased at the price of professional surrender? Are ethics and morality negotiable? Does one's moral code have to bend to suit the times? Is morality old-fashioned and something to be ashamed of? Is a code of ethics that has made medicine the most honorable of all professions to be abandoned?

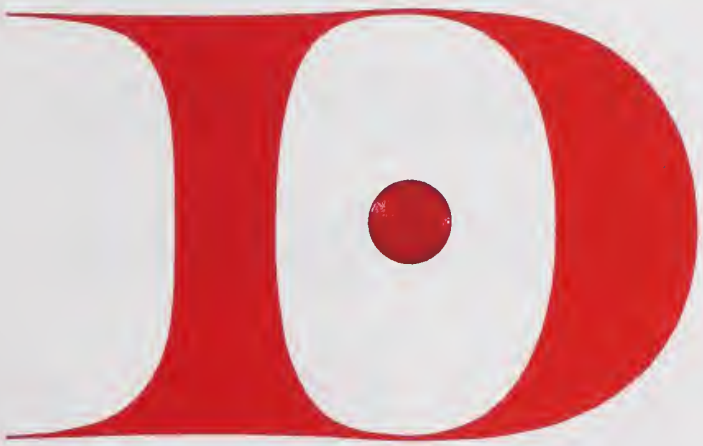
These questions should not be difficult for the physician to answer. The obvious answers are part of him. He deals daily with life and death. There is no compromise with ethics and morality, just as there is no compromise with death. If one does take the first step in compromising honor and morality, he can be sure that he will take the next.

Once he has given in, ever so little, to Federal intrusion, he can be sure it will be easier the next time to give in a little more and he will eventually become defenseless. Arguments to the contrary have paved the way to slavery and destruction throughout history.

"Is life so dear, or peace so sweet, as to be purchased at the price of chains and slavery? Forbid it, Almighty God. I know not what course others may take, but for me, give me liberty or give me death." These historic words spoken by Patrick Henry are as applicable today as they were on March 23, 1775.



an innovation in broad-spectrum antibiotic dosage



DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE

New 300mg

Film-coated tablet

For adult therapy

One mid-morning
One mid-evening

it's made for

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE
300mg FILM COATED TABLETS

One mid-morning **One mid-evening**

provides a full 24 hours of therapy for adults with all the extra benefits of DECLOMYCIN ...lower mg intake per day...proven potency ...1-2 days' "extra" activity to protect against relapse or secondary infection

b.i.d.

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE

300mg FILM COATED TABLETS

DECLOMYCIN® Demethylchlortetracycline HCl TABLETS (Film Coated)

Available dosage forms: Film Coated Tablets containing 150 mg. and 300 mg. demethylchlortetracycline HCl.

ACTION: DECLOMYCIN Demethylchlortetracycline is a broad-spectrum antibiotic derived from a strain of *Streptomyces aureofaciens*. Demethylchlortetracycline is closely related chemically to tetracycline and has been shown to have several advantages which make it a valuable aid to antimicrobial therapeutics. It has a greater antibiotic potency which makes it possible to achieve therapeutic activity with less weight of antibiotic. It has a greater stability in body fluids due to a slow degradation. It has been shown to have a reduced renal clearance rate which produces a prolongation of the antibacterial levels in the body.

The average adult daily dose of DECLOMYCIN Demethylchlortetracycline (600 mg.) may be considered to be the equivalent of 1,000 mg. of tetracycline per day.

INDICATIONS: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

The following conditions have been successfully treated:

Abscess
Acne
Bronchiectasis
Bronchiolitis
Bronchitis
Bronchopulmonary Infection
Cellulitis
Cystitis
Endometritis
Erysipelas
Furunculosis
Genitourinary Infection
Laryngotracheitis
Mixed Bacterial Infection
Non-Specific Urethritis
Otitis (Externa or Media)
Pharyngitis
Pneumonia
Pre- and Postoperative Prophylaxis of Infection
Primary Atypical Pneumonia
Primary and Secondary Syphilis
Pustular Folliculitis
Pyelonephritis
Pyoderma
Sinusitis
Streptococcal Sore Throat
Tonsillitis

associated with tetracycline-sensitive organisms such as the following:

Eaton Agent
Endamoeba histolytica
Hemophilus influenzae
Pneumococci
Escherichia coli
Gonococci
Shigellae
Staphylococci
Streptococci

Evaluation in other infections and conditions is continuing.

DECLOMYCIN Demethylchlortetracycline is indicated for surgical and dental preoperative and postoperative prophylaxis of infection in contaminated fields. Since penicillin is the drug of choice for syphilis and gonorrhea, it should be employed in these infections except in patients with a history of penicillin allergy.

In cases of acute gonococcal urethritis where a primary or secondary lesion of syphilis is suspected, proper diagnostic procedures including darkfield examination should be followed. In all other cases where concomitant syphilis is suspected, serological tests should be made monthly for at least three months.

In patients with agammaglobulinemia or hypogammaglobulinemia and recurring infections, it is necessary to treat with both gamma globulin and an antibiotic such as DECLOMYCIN Demethylchlortetracycline.

DECLOMYCIN Demethylchlortetracycline shows activity against some strains of *Pseudomonas* and *Proteus* heretofore unresponsive to tetracycline therapy as shown by both *in vivo* and *in vitro* studies.

In the treatment of staphylococcus infections, indicated surgical procedures must be performed in all cases.

WARNING: If renal impairment exists, even usual oral or parenteral doses may lead to excessive systemic accumulation of the drug and possible liver toxicity. Under such conditions, lower than usual doses are indicated and if therapy is prolonged, demethylchlortetracycline serum level determinations may be advisable.[1,2,3]

A photodynamic reaction precipitated by direct exposure to natural or artificial sunlight has been observed in some individuals. Small amounts of drug and short exposure to these sources of sunlight may produce an exaggerated sunburn reaction which may range from erythema over the exposed parts of the body to severe skin manifestations. In a smaller proportion, photoallergic reactions to this drug, as well as other tetracycline derivatives, have also been reported.

Such patients should be warned to avoid direct exposure to natural or artificial sunlight while under treatment and to discontinue the drug at the first evidence of skin discomfort.

Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

PRECAUTIONS AND SIDE EFFECTS: The use of antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.

Demethylchlortetracycline may form a stable calcium complex in any bone forming tissue with no serious harmful effects reported thus far in humans. However, use of demethylchlortetracycline during tooth development (= last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (=yellow-grey-brownish). This effect occurs mostly during long-term use of the drug but it has also been observed in usual short treatment courses.

As with all other antibiotics, side reactions which might be encountered include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Rare cases of anaphylactoid reactions have been reported following demethylchlortetracycline. Appropriate precaution is advised.

With full therapeutic doses in infants, increased cranial pressure with bulging fontanels has been observed. The frequency has been rare and all signs and symptoms have disappeared rapidly upon cessation of treatment.

ADMINISTRATION AND DOSAGE: *ADULT:* The average daily adult dosage is 4 divided doses of 150 mg. each or 2 divided doses of 300 mg. each.

An initial dose of 300 mg. may be used in the more severe infections, but a single dose exceeding 300 mg. is thought to be unnecessary.

INFANTS AND CHILDREN: The dosage is 3 to 6 mg. per pound body weight per day or 6 to 12 mg. per Kg. per day, divided into 2 or 4 doses dependent upon the severity of the disease. This should not be given with milk formula or other calcium containing foods and should be given at least one hour prior to feeding.

Because of the cumulative effect in the body, continuation of high doses beyond the first few days is thought to be unnecessary.

Therapy should be continued beyond the time when characteristic symptoms or fever have subsided; however, DECLOMYCIN Demethylchlortetracycline, because of its unique property of prolonged stability in body fluids, permits serum activity for 24 to 48 hours after the last dose. The incidence of rheumatic fever or glomerulonephritis following streptococcal infections suggests that therapy of a streptococcal infection should be continued for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg. in 3 divided doses for six days.[4,5,6]

In the treatment of pustular acne vulgaris an initial dose of 600 mg. daily for one or two weeks may, in most cases, be reduced to 300 mg. or 150 mg. daily for remainder of treatment course.[7]

Absorption is impaired by the concomitant administration of high calcium content drugs such as some antacid medications, foods and some dairy products such as milk. Oral forms of demethylchlortetracycline should be given 1 hour before or 2 hours after meals.

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THE INSURANCE PAGE



Insurance Fees to Interns and Residents

AT THE recent AMA meeting in New York a subject of great concern to private physicians was discussed at length: Payment of medical and surgical fees by insurers to hospitals on behalf of interns and residents or salaried physicians who perform the professional services.

This practice has been widespread for several years, and relates not only to Blue Shield, but commercial insurers as well. The fees involved amount to considerable sums of money. It was stated that one Eastern hospital collected in excess of one million dollars in 1964 from these fees. This money in many cases is used to provide extras for the intern and resident staff, such as trips to scientific meetings, etc., but in other cases it is used to hire or supplement salaries of full time physician/department heads and hospital physicians. The hospitals, quite understandably, are eager to continue receiving these fees.

Many private physicians are becoming increasingly concerned with the potential threat of hospitals entering the practice of medicine by this approach. There were many complaints, especially from urban centers, about the competition from hospitals for private patients. It was noted that one New York hospital, encouraged by this professional income, was able to sign a contract with a Labor Union to provide full medical care (outpatient as well as inpatient) for the Union members. These arrangements were made without consulting either the local Medical Society or the medical staff of the hospital, and the only notification to them was provided by a letter *after* the contract was signed. The local Medical Society expressed strong disapproval of both the contract and the procedure employed.

This problem is not amenable to a single solution, since there exists such a variety of medical insurance contracts and methods of payment. In several states the payment of these fees is directed by insurance commission regulations or by enabling legislation.

Basic AMA policy states "That a medical care plan, sponsored by a State or County Medical Society, must adhere to policies established by that Society, in light of customs, practices and legal requirements prevailing in its jurisdiction." This concept of local plan responsibility was also fully recognized by the National Association of Blue Shield Plans at its April 1965 conference by adoption of the following: "The National Association of Blue Shield Plans believes that payment for professional services rendered by residents and interns by its member plans is a matter for local determination by the governing board of each Blue Shield Plan" . . .

After lengthy discussion in the AMA House of Delegates, the following resolution passed with strong support. "Resolved that this House of Delegates approves and supports the principle that Blue Shield medical-surgical insurance benefits should be paid only to private physicians for eligible professional services personally rendered to their private patients; and be it further resolved, that this House of Delegates report its action to the National Association of Blue Shield Plans and to all constituent associations and component societies of the AMA for the purpose of encouraging widespread adherence to this principle."

WILLIAM W. HALL, M.D.

Butazolidin®
brand of phenylbutazone

in osteoarthritis



Geigy

Therapeutic effects
A number of investigators report improvement in about 75% of cases. Relief of pain and stiffness is the predominant response. Frequently, there is also a significant improvement in function. The beneficial effects of the drug are usually seen by the third or fourth day of treatment.

There is general agreement that milder cases of osteoarthritis are preferably treated by simple analgesics. In many patients, however, this mode of therapy fails to give sufficient relief. Because steroids are not very effective in this form of arthritis, phenylbutazone affords the drug therapy most capable of relieving the more severe cases. For best results, it is recommended that treatment with phenylbutazone be combined with physiotherapy and other appropriate supportive measures.

Dosage
The initial daily dosage in adults is 300-600 mg. in divided daily doses. In most instances, 400 mg. daily is sufficient for maximum therapeutic response. A trial period of one week is adequate to determine the effects of the drug; if there is no improvement, discontinue the drug. When improvement does occur, dosage should be promptly decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning: If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Side effects
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Contraindications
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient cannot be seen regularly, when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin® alka are contraindicated in patients with glaucoma.

Note: The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

Butazolidin alka

Each capsule contains:	
Butazolidin, brand of phenylbutazone	100 mg.
dried aluminum hydroxide gel	100 mg.
magnesium trisilicate	150 mg.
homatropine methylbromide	1.25 mg.

Butazolidin
brand of phenylbutazone
Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
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to help relieve pain
in common
anorectal disorders

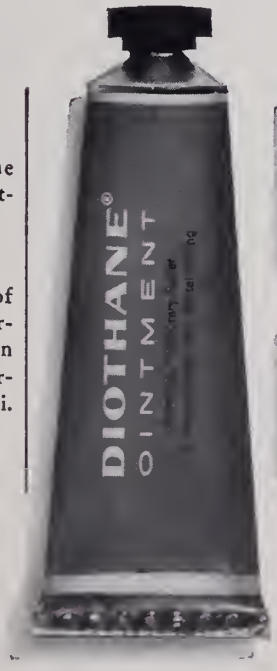
"non-caine" Diothane®

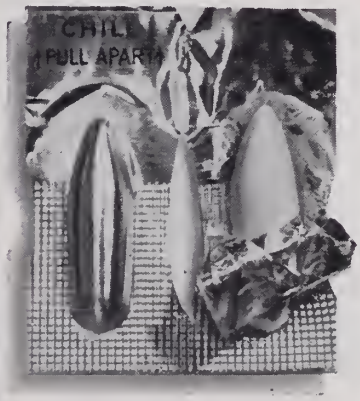
Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

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)MPOSITION:
perodon 1.0%; oxyquinoline nzoate 0.1% in a special oint-nt base.

IDICATIONS:
ovides temporary palliation of in that may result from hemor-oidectomy and from common orectal disorders such as hemor-oids, anal fissures, pruritus ani.





DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

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references: 1. Winfield, I. W.: Am. J. Gastroent., 31:438, 1959. 2. Blanchard, K.: Rocky Mt. Med. J., 54:527, 1957.

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It produces an intense, prolonged increase in
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to help the cough remove its cause.
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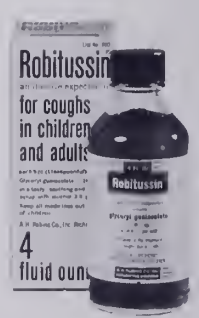
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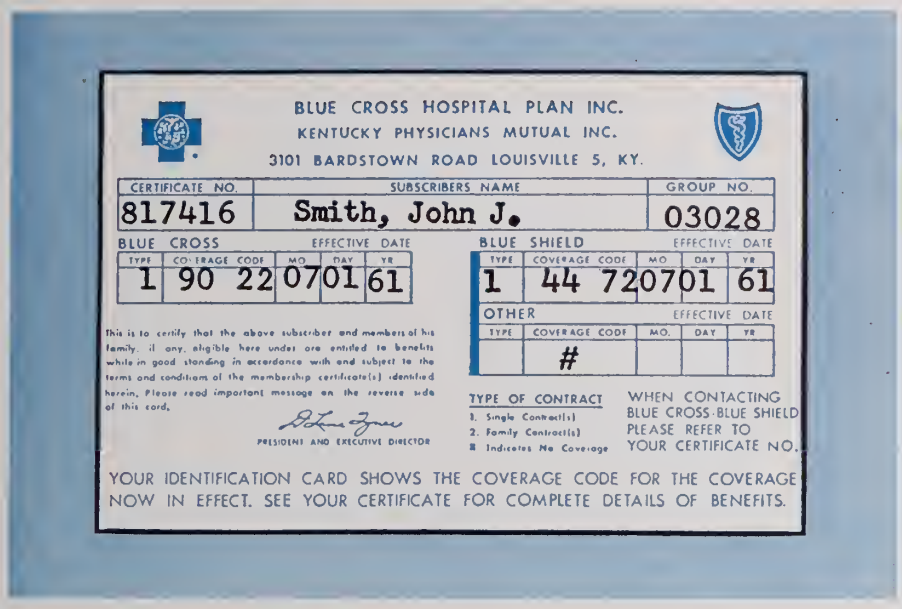
Each 5 cc. tsp. contains:
Glyceryl guaiacolate 100 mg.
Pheniramine maleate 7.5 mg.
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See product literature for
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*Boyd, E.M., and Ronan, A.K.: Am. J. Physiol., 135:383, 1942.

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Endotoxic Shock in the Obstetric Patient†

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Maternal deaths due to infection have more than doubled in many metropolitan areas over the past two years, largely due to changing patterns of bacteria and endotoxic shock. Early diagnosis and appropriate therapy can greatly improve survival rates.

UNDER the auspices of Doctor Philip Williams, the first educational maternal mortality committee in this country began operations in 1930. The reporting of every puerperal death occurring within Philadelphia has been directed to and reviewed by this committee uninterruptedly to date. The downward plunge of maternal deaths due to infection noted in the antibiotic era of the '40s, continued into the '50s when deaths due to this cause reached a low plateau. This trend was noted throughout the United States. Vital statistics published by the United States Public Health Service in 1960 applicable to the year 1958 showed that maternal deaths due to infection comprized 19.8 per cent of the total, (toxemia 25.2 per cent, hemorrhage 29.8 per cent and all others 25.2 per cent). Thereafter, deaths due to infection rose alarmingly and in Philadelphia over 50 per cent of maternal deaths occurring in the past two years have been attributable to sepsis.

The increased occurrence of serious infections complicating all stages of pregnancy is not limited to any particular area of the United States. The obstetric-gynecologic divisions of hospitals in many metropolitan areas are experiencing similar increases. The Sloane Hospital in New York City reported that the number of septic abortion admissions doubled in the past five years.[6] The City of Baltimore[2] showed a similar increase. Infection was the most common direct cause of maternal death in the state of Michigan in 1961 and according to Anderson[1] an average of ten patients per day were admitted to the Los Angeles County General Hospital suffering from septic sequelae of abortion in 1962.

These mounting morbidity and mortality rates due to sepsis have spurred clinical and laboratory investigations concerning 1) cause of the increased incidence of infection in puerperal woman, 2) mechanisms leading to their deaths and 3) more effective methods of combating relentless progression of the shock process when it is associated with sepsis.

Etiology and Mechanism

Of greatest importance is the changing pattern of bacteria associated with puerperal infections and their altered resistance to antibiotic agents. Gram negative bacilli, E. coli, aerobacter, proteus and klebsiella are now the common offenders. Their deleterious effects are due to the endotoxins contained in the bacterial cell wall. Unless the process can be reversed within a matter of hours fatality is the rule.

There were 29 deaths due to abortion on the

†*Presented at the third General Scientific Session of the KMA Annual Meeting, September 29-October 1, 1964, in Louisville.*

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obstetric-gynecologic divisions of the Philadelphia General Hospital in the past ten years. All but four of these were directly attributable to infection. At the Woman's Medical College Hospital the clinical situations in which these infections have appeared are, in order of frequency, 1) septic abortion, 2) pyelonephritis, 3) parametritis, 4) premature rupture of the amniotic membranes, one of which followed a Shirodkar operation, and 5), ruptured tubo-ovarian abscess. The fact that urinary tract infections, especially during labor, can be the causative agent in puerperal infection with endotoxic shock deserves emphasis because of the difference in management, particularly with respect to the avoidance of surgical intervention so often necessary in infections arising in the pelvis.

The lethal effects are basically related to marked increase in peripheral vascular resistance. [3, 4, 5] Intense vasoconstriction is a property of the endotoxins found as lipopolysaccharides within the cell wall of the gram negative micro-organisms[9, 10]. Peripheral blood flow rates are critically reduced and blood is pooled in inactive areas. In turn, venous return to the heart and cardiac output are diminished and profound hypotension develops. Early in the course of the shock process leukopenia is found, especially in reduction of polymorphonuclear leukocytes. This phase is often missed because there is usually a marked increase in neutrophils within four to six hours. Terminally there may again be a reduction. The kidneys are the most susceptible target organ and failure to establish renal blood flow within a reasonable period of time may result in late death due to renal failure. The renal insult is often unrecognized if death occurs within the first ten days. Coronary blood flow is reduced. Many patients demonstrate electro-cardiographic signs of myocardial ischemia with death in two to three days. Mortality rates are about 80 per cent unless appropriate therapy is administered within a matter of hours. These rates are similar to those encountered in the standard experimental shock preparations of Wiggers, Lillehei and others. This high mortality rate can be greatly reduced by rapid intervention and a planned course of action based upon the current concept of the pathophysiology of endotoxic shock.

Evaluation of "Progressive" Shock

1. *Estimation of blood loss.* This is a primary step. If bleeding has not contributed to the shock state, whole blood may be a poor choice for initial therapy. The hemoglobin, hematocrit, white cell count and differential along with the history give only a rough estimate of the situation. One of the pitfalls is that the fluid portion of the blood may be lost at the site of anoxic, damaged capillaries as the shock progresses and the hematocrit may be normal although the blood volume is low. Central venous pressure measurement via catheter threaded into the vena cava from a peripheral vein provides this information most accurately.

2. *Determination of the type and source of infection.* Cultures and sensitivity determinations from blood, urine and material from the uterine cavity should be obtained before antibiotics are started. Cul-de-sac puncture is carried out in almost every case and any material obtained is cultured. Gram's stain of the smear should be done as an initial screening procedure.

3. *Evaluation of renal function.* Since the kidney is the first target organ critically compromised, urinary output must be assessed meticulously and blood urea nitrogen, serum electrolyte and pH determinations obtained.

4. *Evaluation of the cardiopulmonary status.* Pulmonary edema can develop without elevation of the central venous pressure and without hypervolemia. This is apparently due to direct injury of the alveolar capillaries by the bacteria or their toxins. Likewise evidence of myocardial ischemia is not infrequently noted in cases showing prolonged hypotension. Examination of the lung fields, venous pressure and ECG should be made serially.

Plan of Management

1. *Control infection.* Chloramphenicol has proved most useful in the group of gram negative organisms producing endotoxic shock. It should be given parenterally in doses of 3 to 4 gm. per 24 hours. Penicillin should also be given in massive doses of approximately 30,000,000 units per 24 hours. Its value should not be under-estimated in what is generally thought of as penicillin-resistant infections. Weinstein[12] and his associates have shown the susceptibility of many gram negative organisms to massive

intravenous doses of penicillin G. Our experiences corroborate these findings. Many clinicians add streptomycin to the regimen. If this drug is employed it should be administered on a dose by dose basis of 0.5 gm. every six hours and if renal shut-down is imminent the drug should be stopped because of its cumulative toxic effects. Kanomycin sulfate (Kantrex) holds promise but as a rule this drug is avoided because of potential nephrotoxic effects.

2. *Combat vasospasm and correct circulation defect.* This aspect of treatment is most controversial. Our results have been greatly improved since we have curbed the desire to treat the hypotension encountered in all patients with endotoxic shock by use of vasoconstrictor drugs. The intense vasospasm induced by the direct action of the endotoxins on small arteries and veins must be overcome in order to achieve organ perfusion and to improve venous return and cardiac output. The glucocorticoids appear to exert both cardiotonic and direct vascular effects.[5,7] Although the mechanism of action is not yet clear, Lillehei[5] suggests that pharmacologic doses of this steroid may reduce the sensitivity of the vascular end-organ to the action of toxins. These patients are not suffering from hypofunction of the adrenal cortex and thus the desired effects are obtained only if doses far in excess of the physiologic range are used. 1 gm. of hydrocortisone is given intravenously during the first hour. This is repeated in two hours if necessary. A total of 2 gm. per day is continued for two days, after which the blood pressure should be thoroughly stabilized. Abrupt withdrawal without gradually reducing the dosage has not been complicated by any evidence of adrenal insufficiency. This is probably due to the short duration of massive dose administration.

Fluids (usually 5 per cent glucose in saline) are started immediately. Blood transfusion is given only if there is evidence of blood loss. Although Dextran is a good plasma expander it is avoided because of the increased tendency toward coagulation defect associated with septic shock. Blood or plasma can be given cautiously as long as the central venous pressure is low, but overloading is to be avoided. Insertion of the Foley catheter and meticulous monitoring of the intake-output is mandatory.

Vasodilators such as Dibenzyline decrease the peripheral resistance far more effectively than hydrocortisone but the increase in vascular space resulting from the adrenergic blockade causes further hypotension unless blood or plasma is administered simultaneously. Thus far, hydrocortisone has proved satisfactory and probably safer. Vasoconstrictor drugs accentuate the existing problems of vasospasm and are now rarely used on our service. If they are, it is for very short periods of time.

Surgery

Less than 50 per cent of our patients have positive blood cultures. Admittedly only the cultures obtained before antibiotic therapy are valid. Nevertheless, as long as the infected products of conception remain, endotoxins and possibly bacteria continue to be fed back into the circulation. In recent years we have taken an aggressive approach to this problem with rewarding results. If the blood pressure is not restored to normal within an hour or two the uterus is evacuated, sometimes under uterosacral block. Intravenous Pitocin is given in increasing doses if the gestational size exceeds 12 weeks. Usually the abortion is incomplete. Attention is paid to the amount of tissue obtained. It has appeared to us that when a minimal amount of tissue remains in the uterus and the patient is in septic shock, the infection is beyond the endometrium and usually involves at least the uterine sinuses. Occasionally removal of the chronically infected decidua is sufficient to reverse the process but often when small amounts of tissue are obtained hysterectomy becomes necessary.

Hysterectomy is performed within a matter of hours, approximately four to six, if the hypotension persists at shock levels after the uterus is emptied or when induction fails. Laparotomy is performed immediately if the cul-de-sac puncture reveals purulent material. This finding suggests uterine perforation or ruptured postabortal abscess. Under these circumstaces prompt hysterectomy and drainage through the vaginal cuff or cul-de-sac may prevent an almost inevitable fatality. Drainage alone is insufficient. Some of our patients with septic abortion have been admitted in endotoxic shock and the duration of the hypotension can not be determined. The steps described above have been taken systematically yet the shock state persists. In some of these hysterectomy has been performed under hypothermia although the patient appears moribund and an extremely poor operative risk. Even under these condi-

tions there is a chance for recovery in the otherwise healthy young woman if the shock state has been of less than 12 hours duration. Our over-all mortality rate in the past three years has been 25 per cent. This could be considerably reduced if the interval between the onset of septic shock and the institution of treatment could be shortened.

Summary

The gravid woman is particularly susceptible to the development of septic shock. Successful management depends upon early specific diagnosis, institution of massive antibiotic therapy, relief of intense vasoconstriction and restoration of blood volume by appropriate replacements.

Administration of large doses of hydrocortisone has not been attended by untoward effects and is a valuable aid in overcoming peripheral resistance.

Vasoconstrictor drugs accentuate the existing problem of vasospasm and should usually be avoided.

Removal of the infected products of conception and decidua should be carried out if hypotension persists after the first hour or two of medical therapy.

Hysterectomy is indicated if the shock state persists for several hours after the uterus is emptied, if induction fails and the uterus is over 12 weeks' size or if the cul-de-sac puncture reveals purulent material.

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Cataract Removal in the Young Patient† Aspiration Technique

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An aspiration technique for the removal of cataracts in children and young adults is described and recommended. Ten operative cases are presented.

Introduction

THE classic techniques for the surgical removal of cataracts in the young patient have been single or multiple discission, linear extraction or a combination of the two. Although undoubtedly used by the ancients, Percival Potts is given credit for the discovery of discission in 1775. Daviel,[1] in 1748, introduced cataract extraction through a corneal incision though Gibson,[1] in 1811, is regarded as the developer of the linear extraction as we know it today. More recently, lysis of the lens zonules by alpha-chymotrypsin has facilitated intracapsular extraction of cataractous lenses but is not deemed advisable by most authors in patients under twenty years of age due to the extremely high rate of complications, principally vitreous loss. Girard,[2] in 1962, found the explanation of frequent vitreous loss in the young patient to be due to lenticulo-vitreal adhesions, and increased rate of intraocular pressure under general anesthesia, an increased structural pliancy of the globe or an occasional failure of lysis of the zonules by the enzyme.

A fourth method of extraction is the aspiration technique. The first reference to this procedure is by Langier,[1] in 1846, though it is believed to have been used as early as the fourth century. Other articles in the literature advocating aspiration are by Dean,[3] 1926, Wilder,[4] 1928 and Blaess,[5] 1938. Scheie[6, 7], in 1960, introduced his modification of the aspiration technique on congenital or soft cataracts in children or adults up to age thirty. It is his method which we have used and describe as follows.

†Presented at the meeting of the Kentucky EEN&T Society October 1, 1964, during the 1964 KMA Annual Meeting in Louisville.

Scheie Aspiration Technique

The procedure is performed under general anesthesia in children or local anesthesia in cooperative adults. Maximum pupillary dilation is obtained pre-operatively with atropine sulphate (one per cent) and phenylephrine HC1 (ten per cent).

A. Complete Cataract. An eye speculum is inserted and a superior rectus suture is placed. A small limbus-based flap is designed at the twelve o'clock position. The eye is fixed with fixation forceps at six o'clock and a Ziegler knife needle is inserted into the anterior chamber 1.5 mm. behind the limbus and in a plane parallel with the iris. A wide cruciate incision is made through the anterior capsule of the lens and the knife needle withdrawn, enlarging the scleral opening slightly on emergence to permit entrance of the aspiration needle.

The needle is a specially made, thin-walled No.19 needle (with an aperture equivalent to a No. 18 needle) with an oval tip of the type described by Atkinson[8] for retrobulbar anesthesia and is attached to a two cc. syringe containing a small amount of saline solution. It is inserted, bevel down, through the scleral incision and, when well into the anterior chamber, is rotated, bevel up, so that the aperture faces the cornea to prevent injury to the vitreous when suction is applied. By withdrawing the plunger of the syringe, lens material is aspirated. The tip of the needle is directed to various positions in the anterior chamber to facilitate the aspiration and even dense central nuclear plaques can readily be sucked into the lumen of the needle. The needle can be inserted more than once by injecting saline ahead of its entry to deepen the chamber to protect the intact posterior capsule and vitreous face. The stream of fluid can be used to break up resistant lens material and facilitate its aspiration. After reformation of the chamber with saline or air, the scleral incision is closed with a single 6-0 mild chromic catgut appositional suture followed by closure of the conjunctival flap. Pupillary dilitation is main-

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Maintenance dosage may be as low as one fourth the therapeutic dose.

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tained post-operatively by the continued use of atropine and, if necessary, phenylephrine. Topical steroids are a useful adjunct to reduce undue inflammatory reaction.

B. Incomplete Cataract. If the cataract is incomplete, a preliminary discission of the anterior capsule should be performed with no attempt made to stir up the cortex. Pupillary dilation is maintained and the eye is observed for several days. When the lens material is opaque and softened due to the action of the aqueous, the operation described for complete cataract is performed. Diamox® may be needed in the interim if secondary glaucoma arises due to the intumescence of the lens protein. Prompt aspirations of the lens material alleviates the glaucoma.

The following table summarizes five traumatic cataracts, three congenital cataracts and two secondary cataracts performed in children or young adults using the Scheie aspiration technique.

Although the number of cases presented is too small to warrant statistical analysis, the final visual results in the traumatic and secondary cataracts are worthy of note. Of the seven cases in these categories, all have a visual acuity of 20/30 or better. No series of purely congenital cataracts, which are notoriously associated with additional ocular abnormalities precluding good vision (56 per cent in a series by Owens and Hughes[8]) could be expected to have as good visual results as the former types which are assumed to have had previously well developed visual acuity. Falls,[9] in 1943, found only 35.5 percent of 233 eyes with congenital cataracts obtained a final visual acuity of 20/40 or better using standard surgical techniques. Owens and Hughes[8] in 1948 and Bagley[10] in 1949 concluded in their series that better visual results were obtained in linear extraction than in single or multiple needlings.

Discussion

The principal advantage of the aspiration technique other than its simplicity of performance is the apparent reduction of post-operative complications. The lack of morbidity with a relatively quiet eye is striking as there is usually only a minimum of residual cortical material to produce a reaction. An intact posterior capsule offers protection for the vitreous face although Scheie has found that as time goes on a posterior capsulotomy is frequently necessary. Two of the ten eyes reported have to date needed this procedure, though in other instances,

TABLE I

PATIENT	AGE	DIAGNOSIS	PROCEDURE	DATE	ADDITIONAL SURGERY	LAST VISION	DATE
J.H.	16 yr.	Traumatic Cataract	Scheie Aspiration	5/11/61	None	20/20	2/1/62
T.M.	8 mo.	Congenital Cataract	Scheie Aspiration	6/15/61	Discission 9/11/61	?	
B.J.	2 yr.	Congenital Cataracts (Bilateral)	O.D. Scheie Aspiration	8/17/61	None	?	
			O.S. Scheie Aspiration	10/26/61	None	?	
J.S.	16 yr.	Traumatic Cataract	Scheie Aspiration	6/13/63	None	20/25	2/1/64
H.D.	17 yr.	Traumatic Cataract	Scheie Aspiration	8/22/63	None	20/20	1/18/64
L.E.	18 yr.	Traumatic Cataract	Scheie Aspiration	11/7/63	Discission 2/6/64	20/20	6/9/64
W.B.	24 yr.	Traumatic Cataract	Discission, Scheie Aspiration	11/18/64 11/23/64	None	20/30	4/22/64
W.H.	22 yr.	Secondary Cataract	Discission, Scheie Aspiration	2/6/64 2/13/64	Repeat Aspiration 5/14/64	20/20	9/11/64
C.R.	21 yr.	Secondary Cataract	Discission, Scheie Aspiration	3/26/64 4/2/64	None	20/20	9/8/64

the posterior capsule has remained remarkably clear.

Discission alone requires multiple procedures with the inherent dangers of repeated general anesthesia and instrumentation of the eye. There is a tendency for organization of non-absorbed lens material and fibrin over the pupillary space resulting in a dense connective tissue membrane difficult to incise. Glaucoma may result from pupillary block. Shrinkage of the organized membrane may produce traction on the structures in the posterior segment of the eye and be more apt to result in late retinal detachment. As noted by Chandler[11] and others, detachment of the retina is more common with discissions than with linear extraction.

Linear extraction, on the other hand, requires a wide corneal incision and adds the possibility of serious wound complications. Incarceration of iris or capsular material within the lips of the wound may lead to post-operative corneal edema or opacification. Vitreous loss during surgery is not unusual, increasing the chances of retinal detachment, updrawn pupil and corneal opacification. Using the aspiration technique over the past ten years, Scheie has never encountered vitreous loss or wound difficulty other than an occasional pear shaped pupil. However, pupillary block is always a threat and pupil dilation must be maintained in the post-operative period. For those pupils which will not dilate well pre-operatively, a preliminary iridectomy is necessary, perhaps best done as a separate procedure.

Summary

Scheie's aspiration technique is described and recomended for surgical removal of cataracts in children and young adults. Ten operative cases are outlined using this procedure and its advantages presented over standard techniques.

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Edwin Paul Scott, M.D.*
Louisville, Ky.

Very few long term follow-ups of Gaucher's disease are available. In the cases presented, this rare familial disease has been followed over a fifteen year period.

THE hereditary aspects of Gaucher's disease have recently been reported. The two cases to be reported herein are brothers who manifested the unusual bone findings of Gaucher's disease, had splenectomies, and have been followed fifteen years after onset of the disease. A cousin is also reported who had Gaucher's disease and splenectomy and is alive at the age of fourteen.

Case One

C. C., a three year, eleven month old white male, entered the Children's Hospital, Louisville, Kentucky, January 17, 1949, with the chief complaint of enlarged spleen. He had been previously admitted to Our Lady of the Way Hospital at Martin, Kentucky, for diagnosis and was transferred to Louisville. At the age of five months the parents noticed a mass in the left upper quadrant of the abdomen. The mass had gradually enlarged until it was down to the groin. The family had taken him to many physicians who had diagnosed anemia and leukemia. At the age of two years an inguinal lymph node was removed and the family was told that the child had Gaucher's disease. Six weeks before admission he had bled from his gums.

Past history revealed a normal gestation and a birth weight of six and one half pounds. Development was normal and the only previous illnesses were varicella and pneumonia. He had been admitted to five other hospitals for diagnosis.

The physical examination revealed a fairly well developed white male child who weighed twenty-six and one half pounds and had a greatly distended abdomen. His temperature was 99.0°. There were a few purpuric discrete lesions on the outer aspect of the right thigh. There was no visible bleeding from the nose or mouth. A mass filled the entire left side of the abdomen. The superficial veins were dilated over the liver area, and the liver was enlarged to four fingers' breadth below the right costal margin. There was moderate enlargement of the cervical, axillary, and inguinal nodes.

Laboratory studies revealed a red blood cell count of 4,320,000 per cu. mm., white blood cell count 6,850 per cu. mm. with a differential of polymorphonuclear leucocytes 47 per cent, lymphocytes 53 per cent, and a hemoglobin of 11 grams per 100 cc. of blood. Repeat blood counts were all within normal limits. The bleeding time was three minutes and clotting time four minutes. Numerous platelet counts always revealed counts above 250,000 per cu. mm. Four separate examinations of the stools failed to reveal ova or parasites; however, occult blood was four plus. The thymol turbity test was 23 units, blood cholesterol 132 mgm. per cent, and cephalin flocculation four plus. The fragility test was normal; the histoplasmin and tuberculin tests were negative. The blood protein was 4.92 grams albumin and 4.14 grams globulin. The akaline phosphatase was 9.85 B.U., and acid phosphatase, 4.82 B.U. The corrected sedimentation rate was 18 mm. in one hour. The urinalysis revealed zero to two plus albumin, but was otherwise not remarkable. A bone marrow study revealed lymphocytic infiltration suggestive of leukemia. The roentgenograms of the abdomen revealed a large mass interpreted as probably spleen. Films of the chest, long bones and skull were normal.

On January 24, 1949, a biopsy of an inguinal lymph node was done. which on section was reported as chronic lymphadenitis. A splenectomy was performed on Febraury 3, 1949, under ethyl chloride and ether anesthesia, and a

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From the Department of Pediatrics, University of Louisville School of Medicine and Children's Hospital, Louisville, Ky. (Case 1)

greatly enlarged spleen was removed. He was transfused before and after surgery and was given penicillin 30,000 units every three hours intramuscularly for five days prophylactically.

Examination of the spleen showed it to be 27 x 13 x 6 centimeters in size. The microscopic sections revealed large eosinophilic cells with a dense basophilic nucleus, consistent with Gaucher's disease. The child was discharged nine days later, February 12, 1949.

He was next seen at the age of nine and one-half years on August 16, 1954, in the Ashtabula General Hospital, Ashtabula, Ohio. His chief complaint was pain which had been present in the right knee for six weeks. The physical examination revealed a chronically ill child with protruberant abdomen. The liver was palpable and extended to the iliac crest. There was some muscle spasm with limitation of flexion, adduction and abduction of the right hip joint.

Laboratory studies revealed hemoglobin of 9.0 grams per 100 cc. of blood, with a white cell count of 18,800 per cu. mm. Sedimentation rate corrected was 39 mm./hr. Roentgenograms of the right femur revealed thinning of the cortex, especially in the distal metaphyseal region consistent with Gaucher's disease. Also there appeared active Legg-Perthes disease involving the right femoral capital epiphysis. Osteoporosis was also observed in the other long bones. His PPD was negative. He was treated symptomatically and discharged four days later to be followed in the out-patient department.

At age ten, he was seen at the Cleveland Clinic in March, 1955, where again his liver was found to be enlarged, extending to the umbilicus. He appeared malnourished and had a yellowish tinge to his sclerae. He walked with a decided limp. Roentgenograms revealed the distal femurs to flare bilaterally in the characteristic appearance of Gaucher's disease. He also showed far advanced involvement of the capital epiphysis of the right femur, the area being almost completely destroyed. His cephalin cholesterol flocculation was four plus at twenty-four and forty-eight hours. Serum bilirubin was normal. Total plasma proteins 9.5 grams, with albumin 3.2 grams and globulin 6.3 grams per 100 cc. He was treated with a device for non-weight bearing on the right leg.

A bone marrow was unsuccessful so the original slides from the splenectomy were reviewed and again confirmed the original diagnosis of Gaucher's disease.

In correspondence this year with his grandmother with whom he now lives, she states he had an appendectomy in 1962, wears glasses is now in "good health," and has just graduated from high school. Although he is now nineteen and one-half years of age, he is extremely small, wearing size twelve clothing.

Case Two

R. C., a one year old male child, was admitted to the St. Joseph Infirmary in Louisville, Kentucky, on August 16, 1949, with the complaints of pallor and an enlarged abdomen. Since he was the brother of Case #1, the father was conscious of the enlarging abdomen. He reported that he had felt a mass which he thought was an enlarged spleen. Since that time it had become progressively larger. Pallor had been noticed for the past two months. Although appetite had been poor, he weighed seventeen pounds.

The family history revealed, in addition to the brother reported in Case #1, a female sibling living and well, with both parents in excellent health. A paternal uncle had a son who died of "pneumonia" at the age of eighteen years. He was four and one-half feet tall and had a very large abdomen with a "tumor mass."

The physical examination revealed a well developed and fairly well nourished white male infant with the following measurements: height twenty-six inches, weight seventeen pounds, chest circumference eighteen inches, abdomen twenty inches and head 15.5 inches. The mucus membranes were very pale and there were many palpable lymph nodes. The anterior fontanelle was open 3 x 3 centimeters. Only two lower central incisor teeth were present. The abdomen was enlarged, with a firm mass in the area of the spleen extending to the left iliac crest. The remainder of the physical examination was within normal limits.

The laboratory studies revealed 1,860,000 red blood cells per cu. mm. with a hemoglobin of 4.2 grams per 100 cc. of blood, and a white blood count of 7,100 per cu. mm. and a differential of polymorphonuclear leucocytes 29 per cent and lymphocytes 71 per cent. Achromia, anisocytosis and polychromia were present. Urinalysis revealed a trace of albumin, but was otherwise negative. Except for the

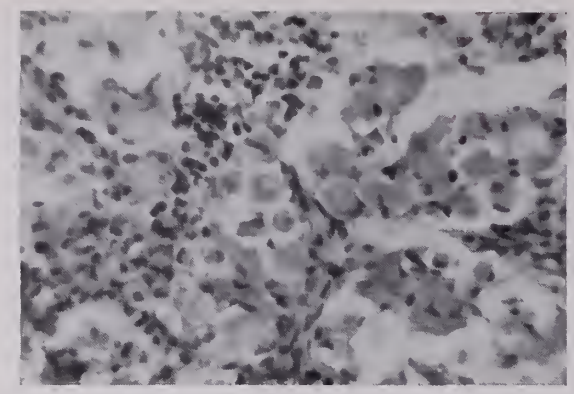


FIGURE 1. Case 2.

splenic mass, roentgenograms of the abdomen and the long bones were normal. The bleeding and clotting times were normal. The prothrombin time was 88.09 per cent of normal and blood platelets 71,640 per cu. mm. A biopsy of the bone marrow failed to reveal any Gaucher cells.

Treatment consisted of three transfusions of whole blood, ascorbic acid 100 mgm. daily, elixir of Pyribenzamine® three drams daily and penicillin 400,000 units intramuscularly daily. On August 23, 1949, under ethyl chloride and ether anesthesia, a splenectomy was performed. The post-operative course was normal except for distension which was controlled by gastric suction, enemas and prostigmine. The blood counts and platelets returned to normal.

The spleen weighed 200 grams and on microscopic section many large reticulo-endothelial type cells were seen which contained nuclei of moderate size with very abundant cytoplasm. The cytoplasm was granular but not foamy or vacuolated and stained pale. The impression was Gaucher's disease (Fig. 1, Case 2). He was discharged fourteen days later on August 30, 1949.

He was readmitted to St. Joseph Infirmary on September 12, 1950, for three days with the complaint of being very tired and inactive. He was transfused twice and returned home.

The patient was next seen at the age of six years on December 6, 1953, at the Ashtabula General Hospital, Ashtabula, Ohio, for an acute respiratory infection with temperature of 103°. The family refused treatment despite the critical appearance of the child. The following day he was readmitted, for the third time, to St. Joseph Hospital, Louisville, Kentucky, on December 7, 1953, for an enlarged abdomen. The family stated that he had been chronically ill since his discharge in 1950, and his abdomen had become progressively larger. He had been very irritable, cried constantly and could not gain weight. He also had a cold and fever for several days.

On admission he weighed thirty pounds and had a temperature of 102°. He appeared chronically ill, emaciated and pale and had an enlarged abdomen. The liver was palpable and extended to the crest of the ileum. Although the spleen had been removed, a mass could be felt in the left upper quadrant of his abdomen. The cervical lymph nodes were palpable and the skin was bronzed in color. The chest revealed rhonchi and moist rales throughout.

Laboratory studies revealed a hemoglobin of 8.7 grams per 100 cc., red cell count 3,330, 0000, white cell count 40,000 and a differential of polymorphonuclear leucocytes 56 per cent, lymphocytes 34 per cent, monocytes 5 per cent and eosinophils 5 per cent. Target cells and occasional stippled cells were present on the stained smear. The urine contained a trace of albumin but was otherwise negative.

Roentgenograms revealed an enlarged liver shadow and bronchopneumonia. Films of the long bones revealed a "flask-like deformity" with thinning of the cortex and demineralization of bone with questionable cytic charges in the left femur. (Fig. 2, Case 2).

The bone marrow aspiration revealed an active marrow and no evidence of blood dyscrasia.

The treatment consisted of two transfusions and antibiotics.

In March of 1956, at the age of seven and one-half years, he was admitted to the Cleveland Clinic Hospital, where he complained of pain and limitation of motion of the right hip; however, the major x-ray findings, which consisted of destructive changes similar to Legg-Perthes disease, were on the left hip. The liver extended to the pubic bone. The cephalin cholesterol flocculation was four plus in 24 and 48 hours. The total serum protein was 8.1 with albumin 2.0 and globulin 6.1 grams per 100 cc.

He was admitted in May, 1956 to the Ashtabula General Hospital for swelling of the right humerus and elbow. The painful swelling had been present for three to four weeks. Again the liver was enlarged, filling the entire addomen. There was a visible venous pattern over the abdominal surface. The elbow and



FIGURE 2., Case 2.

humerus was swollen, hot and tender, with limitation of motion. Roentgenograms of the left hip were consistent with Legg-Perthese disease. Changes were also noted in the trabecular pattern of the pelvis and upper femurs consistent with the diagnosis of Gaucher's disease. The right humerus showed an extensive destructive process involving the entire shaft. A pathological fracture was present about 5 cm. distal to the proximal epiphyseal line. The extreme periosteal reaction was believed to be secondary to the pathological fracture. The red blood count was 2,710,000, white blood cell count 16,650 and hemoglobin 8.2 grams per 100 cc. The bone marrow examination did not reveal Gaucher's cells and was interpreted as normoblastic hyperplasia.

The next hospital admission was in St. Joseph Hospital, Parkersburg, West Virginia, from June 1, 1962, to June 5, 1962. His complaint was sudden pain in the back following lifting a heavy load.

Physical examination revealed a chronically ill patient with darkly pigmented skin. The liver filled the abdomen and in spite of a history of splenectomy a mass was in the splenic area. There was considerable clubbing of the fingers and toes.

Laboratory studies revealed a red blood cell count of 3,200,000 with a hemoglobin of 10 grams per 100 cc. of blood. The white cell count was 12,300 with 45 per cent polymorphoneuclear leucocytes, 47 per cent lymphocytes, 7 per cent monocytes and 1 per cent eosinophils. There were many target cells and 5,912 circulating nucleated red blood cells seen on the smear. Urinalysis revealed albumin one plus and acetone. Microscopic examination revealed 10-12 white cells and 2-3 red cells.

X-ray studies showed extensive osteoporosis with pathological fractures of the fifth and seventh dorsal vertebrae, with complete collapse. (Fig. 3, Case 2). The femurs showed Erlenmyer flask-like appearance and extensive osteoporosis. (Fig. 4, Case 2). Figure 5 shows his appearance in August, 1962, with a protruberant abdomen. His weight was 55 pounds and height 51 inches.

Correspondence in June, 1964 with this patient's father, revealed that after divorce from the patient's mother, the father remarried and now has a year-old daughter who, to date, is not afflicted with Gaucher's disease. The father states he has a cousin with the same disease, (D.B.) who, at one year of

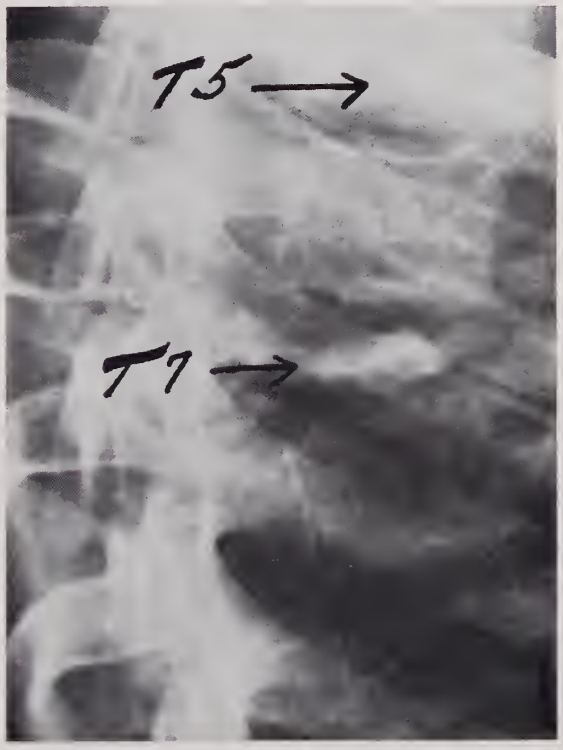


FIGURE 3., Case 2.



FIGURE 4., Case 2.

age was found to have an enlarged abdomen and anemia. After being followed for one year, a huge spleen extending to the iliac crest was removed on May 4, 1954 at the Methodist Hospital, Pikeville, Kentucky.

The final diagnosis was Gaucher's disease, and recent communication reveals he was last seen on March 13, 1962, at the age of eleven years. His growth was retarded, skin deeply tanned and the abdomen was prominent with greatly enlarged liver. Roentograms of both femus revealed osteosclerosis and widening compatible with Gaucher's disease. There was also a pathologic fracture through the distal portion of the left femur.

R. C.'s. final hospital admission was at St. Joseph Hospital, Parkersburg, West Virginia from September 18, 1964 until death on September 30, 1964. One week before his final admission, it was noted his nails were blue. Three days later he seemed tired, listless, had fever and an accompanying respiratory infection. The day of admission he had shortness of breath, cough and chest pain.

Physical examination on admission revealed a temperature of 103°F., pulse 145 and respiration of 48. He was abnormally small, weighing only 40 lbs. His skin was bronze in color and his mucous membranes were deeply cyanotic. Auscultation of the chest revealed rales in the base of each lung. There was no enlargement of the heart by percussion and the rate was rapid but regular. The abdomen was protruberant. The liver was tender and palpable six centimeters below the right costal margin.

Laboratory: Roentgengrams of the chest revealed the heart to be globular in shape, and slightly enlarged. There was slightly increased marking in the lung fields. In addition to the enlarged liver on roentgenograms, there also was fluid in the abdominal cavity. Repeat roentgenogram of the chest on September 28, 1964, showed clearing and the heart no longer appeared enlarged. The red blood cell count was 2,370,000 per cu. mm. with a hemoglobin of 7.9 grams per 100 cc. of blood. The leucocyte count was 5,560 per cu. mm. with a differential of band cells 3%, segmented 67%, lymphocytes 21%, monocytes 8% and eosinophils 1%. There was also 80 nucleated red blood cells per 100 leukocytes. The stained smear revealed marked hypochromia, anisocytosis and target cells. The urinalysis, other than 10 to 15 white blood cells per high power field and an occasional hyaline and granular cast, was not remarkable. His H_2CO_3 was 0.63 and bilirubin 1.5 mgm. per cent. The electrocardiograms on September 25, 1964, and September 29, 1964, revealed sinus tachycardia, suggestive left ventricular hypertrophy and possible digitalis effect.

Course and treatment: He was given digitalis, antibiotics, oxygen and was transfused. He appeared so much better that on his fifth hospital day the digitalis was stopped. His hemoglobin rose to 11.0 grams per 100 cc. of blood and red blood cell count was 4,050,000 per cu. mm.

Two days prior to death he was up and around and going to the hospital playroom, but still complained of tiredness with shortness of breath. The following day, one day prior to death, he complained of pain in the chest beneath the sternum and again became cyanotic. He expired on September 30, 1964, and during the last six hours of life he complained of severe chest and abdominal pain.

(Continued on Page 630)

Some Observations on the Care of the Hemiplegic from the Standpoint Of Physical Medicine

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The care and rehabilitation of a hemiplegic is no longer a matter of natural convalescence. The return of function is not necessarily dependent on the return of power.

HEMIPLEGIA is the paralysis of one side of the body. It is not a disease, but is a symptom complex as a result of numerous and varied pathological processes. Every form of hemiplegia is characterized by paralysis of the upper motor neuron type. Depending on the degree of involvement, there may be complete or partial loss of voluntary motor power and there may be complete or partial return. Usually there are hyperactive deep reflexes and diminished or absent superficial reflexes.

Etiology and Diagnosis

Some of the causes of hemiplegia, not in the order of frequency or effect, are:

1. Cerebral vascular spasm: In this condition there is a sudden onset and the paralysis may be complete or partial, but fortunately it is transient and the prognosis is good for complete recovery.

2. Cerebral emboli: These comprise about five per cent of cerebral vascular accidents (CVA) and the principal etiological factor is atherosclerosis.

3. Cerebral thrombosis: Makes up about sixty-five per cent of all CVA's. The onset is slow and there is often a warning that something is happening, although the feeling may be of only a few seconds duration. It has been described by some patients as "being torn in half" or like being "hit by a bull-dozer." There is a resultant persistent hemiplegia. The principal etiological factor is arteriosclerosis and there is a sixty per cent mortality.

4. Hemorrhage: Causes by far the greatest mortality—ninety per cent. This condition comprises about twenty per cent of all the CVA's. The onset is rapid, and there is a severe hemiplegia.

5. Other causes: Subarachnoid hemorrhage; subdural hematoma; concussion and contusions; brain tumors; neurosyphilis.

If the patient is unconscious, the paralysis may not be evident until consciousness is regained. Usually, musculature of the trunk is spared. Speech and swallowing may be affected, depending on the site of the lesion. Although most forms of acute hemiplegia are flaccid in the beginning (this may be a few weeks), there is a rapid return of the deep reflexes and they soon become hyperactive on the paralyzed side and often, at times, on the unaffected side. A hemiplegia which remains permanently flaccid is quite rare, and presents a very poor prognosis. As tonus increases and muscular power returns, it will usually return first in the lower extremity and then in the shoulder and the more proximal areas of the limbs. The dorsiflexors of the foot and the flexors of the thigh show the least return and are the slowest in the return of function. In the upper extremity, usually finger extensors show the least improvement.

Spasticity and contractures often develop when healing is "left to nature." There is little excuse for letting a contracture develop. When it does, the arm is then held in adduction, the forearm is flexed, the hand is flexed and pronated and the fingers are flexed. However, the

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position of the extremity depends on the degree of spasticity and the degree of contractures.

Usually, paralysis of the face and tongue gradually clears, leaving only slight residua. Occasionally, the deviation in the face toward the paralyzed side remains. Vasomotor disturbances are commonly present on the paralyzed side in the form of cool, bluish, and often edematous extremities. Although there may be a hypoesthesia, it is not always present. And too, the patient may speak of numbness when he means weakness.

In cerebral vascular disease, there may be prodromal symptoms that date back for days, or even months, before the actual vascular accident, which may occur in the form of headache, dizziness, insomnia, irritability, poor memory. These symptoms may occur either singly or in any combination.

It should also be mentioned that hemiplegias without brain damage may ocur in uremia, diabetes, pneumonia, empyema, alcoholism and certain cord lesions.

Treatment

Initially, medical and surgical therapies take precedence, but even then, there is a goal of rehabilitation and the physiatrist will start his treatment and care at that time. The program will become more active when the cerebral lesion is stabilized, and when the patient is capable of cooperation. The attitude of the physicians and nurses may be decisive in the motivation of the patient, for without motivation, rehabilitation will fail. Further, the results obtained by early programs of rehabilitation are far superior to those obtained by programs started months or years later.

Sixty per cent to ninety per cent of the patients with hemiplegia can be taught walking, bowel and bladder control and the activities of daily living. Thirty per cent of these people will work again. It is helpful to assure these patients that if they can raise the affected leg one inch from the bed, they will be able to walk.

The following are some of the more important problems pertaining to the overall care:

1. Prevention of deformities caused by contractures.
 a. Proper positioning by using footboards and sand bags to keep the lower extremity in a neutral and comfortable position, and to prevent outward rotation. The arm should be in abduction, usually. Slings and splints may have to be used.
 b. Range of motion and stretching exercises, active if possible, passive, if not. These may be preceded by heat therapy. This will often prevent the typical shoulder hand syndrome which is most uncomfortable and incapacitating to the individual.

2. Muscle re-education by attempting to develop flexor and extensor groups equally in the upper and lower extremities. Stress should be placed on function, not merely power. As soon as the patient is able to sit up in bed, start with sitting balance. The patient will usually be able to sit without assistance for some time before he is able to get to a sitting position from the supine. Balance exercises can progress to standing balance and here it is helpful to use the tilt table.

3. Ambulation training begins as soon as the patient can stand at the bars unsupported. The training period in the bars at this time is short, in order to avoid fatigue. The first step is a proper stance on the affected leg. The patient begins by standing on the affected leg while taking a short step with the good leg. Gradually the swing phase is increased so that a longer step is taken with the good leg. Deficiencies in the swing phase may be improved by keping the unaffected leg stationary. It is possible that bracing may be necesary for the weakened knee and drop foot. After the patient has learned both phases, he is taught to combine the two into a walking pattern. Modifications in gait may have to be made, depending on muscle weakness, and although it may show an abnormal pattern, he may be allowed to follow it for safety. Later, training will follow in ramps and stairs.

4. Self-help devices, especially in eating and dressing. It may be necessary to use large buttons, pressure fastening devices, rubberized shoe laces, etc. It is usually better to have the bedside table placed on the unaffected side.

5. Other activities to improve and develop coordination, such as the loom and woodworking activities, sanding, and other occupational therapy techniques.

6. Speech and psychotherapy, if necessary. Social adjustment is a very large factor in these individuals, and emotional instability may of-

(Continued on Page 630)

when treatment might precipitate a problem with monilia

especially in elderly or debilitated patients

and in diabetics – patients with a history of fungal overgrowth – patients on steroids who require antibiotics. The antimonilial specificity of Nystatin plus the extra benefits of DECLOMYCIN Demethylchlortetracycline allow lower mg intake per dose per day, the option of b.i.d. dosage, higher activity levels, 1-2 days' "extra" activity.

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EDITORIALS

Come To Louisville

IN THIS issue you will find the program of the KMA Annual Meeting to be held in Louisville September 21st to 23rd, 1965. We invite your attention to the very fine presentations offered and urge that you make every effort to attend.

Be sure to bring your wife. Physicians' wives are divided into two categories. Some feel that medical meetings are no place for them, that they are tiresome and boring, and that going to them with their husbands is no vacation and even somewhat of a nuisance. Others feel differently. We must admit that in recent years the Womens Auxiliary of the KMA has become a very effective force in promotiong good will and understanding of the physicians' problems among people generally. If your wife is not a member of the Auxiliary and not active in its work, bring her along and encourage her to participate. But bring her anyhow.

The changing complex of medical practice and the social, ethical, and economic implications presented by recent legislation are matters about which we need to be informed so that as a profession we can chart an intelligent and effective course for the future. Information, discussion, and decisions in this important field must be made. More than ever we must move together as a profession. Entirely aside from the scientific menu, and the social and recreational opportunities, the privilege of sitting together and discussing our future plans should be a sufficient attraction to us all.

Come to Louisville September 21st to 23rd. Be sure and bring your wife.

SAM A. OVERSTREET,M.D.

Poor Diction

FOR THOSE who read the Editorial in the June 1965 issue of the Journal "What Can Be Done About It," a word of explanation is in order. The sixth paragraph reads:

> "The promptness with which the physician initiates diagnostic studies after the patient's admission and with which desired consultations are accomplished are very important in the length of hospital stay. This matter is complicated by the inability to obtain these services over the weekends or holiday periods, but with diligent care can be greatly improved."

The use of "inability" in the second sentence is an unfortunate choice of words. Difficulty or delay or inconvenience might well have been used instead.

The clinical laboratories and x-ray departments in our hospitals in this area provide for service 24 hours of every day; there is usually little trouble in having emergency work, or even routine examinations, done over weekends and holidays if this is especially desired. The choice of words was unfortunate and we are glad to offer this correction with our apology.

SAM A. OVERSTREET, M.D.

A New Contract

ON JULY 1st of this year there became effective a new contract between the Ford Motor Company and Blue Shield (the Kentucky Physicians Mutual, Inc.), for the provision of more or less total medical care to the employees of the Ford Motor Company and their families. In the bargaining contract with labor organizations Ford had agreed to furnish this care to its employees and had requested Blue Shield to carry the contract. On two successive years the Jefferson County Medical Society had declined to enter into such a contract, but in a reconsideration of the proposal during early part of 1965 they agreed to cooperate with the Kentucky Physicians Mutual in the matter. It had been regarded as necessary to secure at least 75% cooperation of the practicing physicians in order for the program to become effective. More than 80% of them indicated their desire to cooperate.

The proposal came up first during the presidency of Louis Foltz, M.D., and after presentation to the County Society it was voted down. The same decision was reached by vote of the Society in the following year. The president and many others felt that we erred. This opinion was expressed by a number of consulting physicians from other areas where similar steps had been taken.

Doctor Foltz felt that it was far better to have the contract carried by Kentucky Physicians Mutual than by some commercial company, or by an insurance plan conducted entirely by the Ford Motor Company in which the participating physicians would have very little voice. He therefore undertook in the spring of 1965 to inform all segments of the Society regarding the character of the proposal and it was largely from the result of his effort that the Society reversed its decision this year. Doctor Foltz is to be commended for the persistence and goodwill and patience with which he undertook this informative program, and it is believed that he rendered the medical profession in this area a distinctly constructive service.

Roy H. Moore, Jr., M.D., incumbent president of the Society, conducted the long and rather tedious hearings and encouraged a free expression of opinion from all members of the Society who would attend. He exhibited a very fine quality of leadership in this and many other affairs of the Society which have gained him the lasting respect and admiration of the members.

Walter I. Hume, Jr., M.D., is chairman of the Jefferson County Blue Shield Study Committee and spends a great deal of time in coordinating the efforts of the Kentucky Physicians Mutual and the County Society. Without his guidance and the work of his Committee the program would undoubtedly fail.

Mr. Avil McKinney and the entire staff of Blue Shield have been anxious that this program be carried by our own insurance machinery, and during the past three years have worked in closest cooperation with the Ford Motor Company and Jefferson County Medical Society in bringing this contract into effective and satisfactory operation. Their work this year in preparing forms and obtaining from more than 700 individual physicians the outline of fees that would be acceptable to them, coupling these by individual computer analysis, and tailoring a contract agreeable to the physicians has been a detailed, tedious, and time consuming task. Their presentation of this work to the Ford Motor Company and accomplishing an agreement which is satisfactory to them and at the same time acceptable to the Jefferson County Medical Society involved work, judgment, diplomacy and foresight for which they deserve the highest commendation.

The program is new. The Jefferson County Medical Society is the first in the country to reach such an agreement and the operation of the plan will be viewed with considerable interest by Blue Shield and other insurance carriers the country over. We feel happy and grateful that so much has been accomplished. The first year of operation is, of course, crucial and many points of disagreement have yet to be adjusted. Patience, cooperation, tolerance and goodwill will be required on the part of all physicians to make the plan effective. We feel that it will be highly successul and satisactory to the Ford Motor Company and its employees and to the participating physicians alike.

SAM A. OVERSTREET, M.D.

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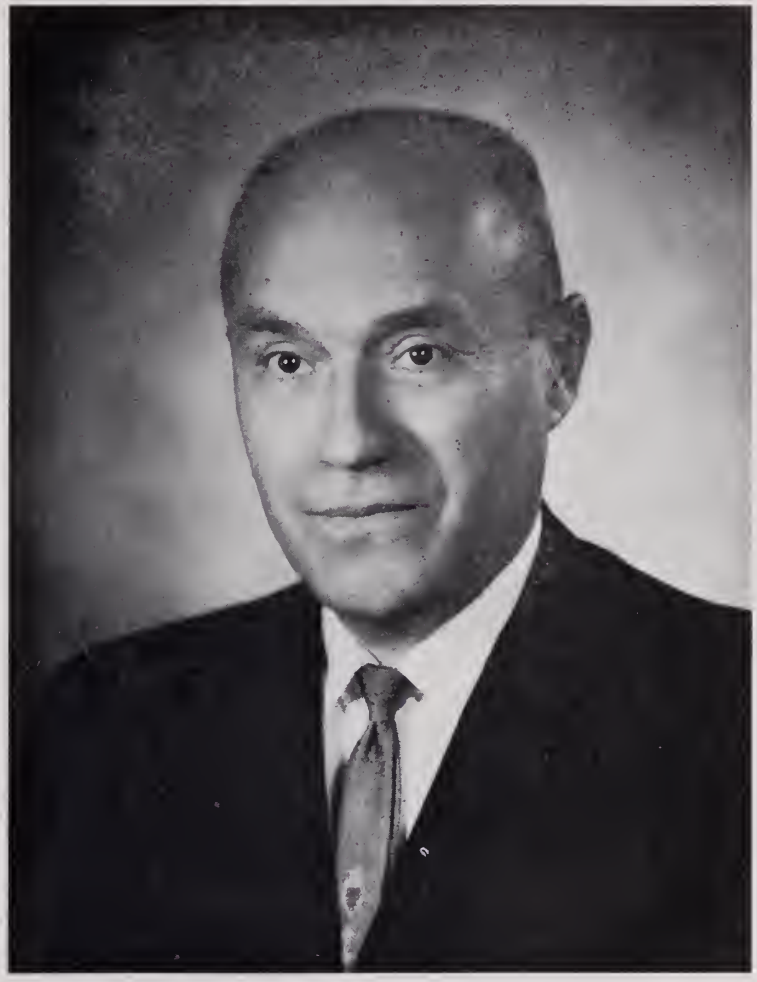
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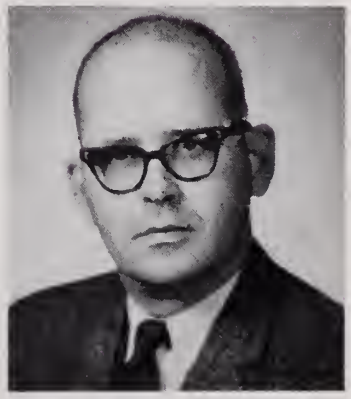




Robert W. Lykins, M.D.
Vice-President (Central)



Harold B. Barton, M.D.
Vice-President (Eastern)



Kenneth M. Eblen, M.D.
Vice-President (Western)

President-Elect

Everett H. Baker, M.D.

Louisville, Ky.

Doctor Baker, a vice-president of the Kentucky Medical Association from the Central district in 1955-56, has also served as president of the Jefferson County Medical Society and is currently chairman of the Board of Governors of the JCMS.

A native of Louisville, Doctor Baker attended military school—the Louisville Training School—and graduated from Vanderbilt University in 1921. He received his medical degree from the University of Louisville School of Medicine in 1925. Following this he interned at Louisville General Hospital and was a resident at Children's Hospital from 1926-27.

A talent for music enabled him to work his way through school by playing the piano and organ at various local theatres and hotels. Music remains one of his many hobbies. He also enjoys playing tennis for amusement and exercise.

Doctor Baker practiced medicine in Louisville from 1927 to 1942, when he became a captain in the medical corps of the U.S. Air Force. He was discharged in 1946 with the rank of lieutenant colonel.

In 1946, following his discharge from service, he did postgraduate work in anesthesiology in New York City and at the Mayo Clinic in Rochester, Minn. In 1948 he was made a diplomate of the American Board of Anesthesiology.

Active in KMA for many years, he is a member of the Board of Directors of Kentucky Physicians Mutual, Inc. (Blue Shield), and several years ago was a member of the KMA Committee to study the Constitution and Bylaws.

Doctor Baker was president of the Kentucky Society of Anesthesiology in 1948, and president of the Louisville Society of Anesthesiologists in 1958. That year he was also president of the medical staff at St. Joseph's Infirmary, where he is currently chief of the anesthesiology department.

The KMA president-elect is an active participant in the affairs of his church and community. In addition to his current position as chairman of the Board of Stewards of Beechmont Methodist Church, where he has taught Sunday School for 20 years, he is on the Board of Directors of the Volunteers of America.

His outstanding record of service to medicine and his community, coupled with his leadership, loyalty to his profession, and his personal integrity, made Doctor Baker the natural choice as president-elect.

VICE PRESIDENT, CENTRAL

Robert W. Lykins, M.D., Louisville

Doctor Lykins, a 1946 graduate of the University of Oklahoma School of Medicine, has served as secretary of the Jefferson County Medical Society, chairman of its Council on Community Service, and chairman of Operation Hometown. He was assistant secretary last year of the American Society of Anesthesiologists, and is currently chairman of the Committee on Credentials and the Committee on Professional Relations for that group. In 1954 he was secretary-treasurer of the Kentucky Society of Anesthesiologists, and delegate from Kentucky to the ASA from 1957 to 1960.

VICE PRESIDENT, EASTERN

Harold B. Barton, M.D., Corbin

A general surgeon and a native of Madison County, Doctor Barton is currently serving as chairman of the Board of Directors of the Kentucky Educational Medical Political Action Committee (KEMPAC). He was graduated from the University of Kentucky in 1948 and the University of Louisville School of Medicine in 1952. Following completion of his surgical residency at Louisville General Hospital, Doctor Barton entered practice at Corbin in 1957. A Fellow of the American College of Surgeons, he is a former delegate to KMA from the Whitley County Medical Society.

VICE PRESIDENT, WESTERN

Kenneth M. Eblen, M.D., Henderson

Doctor Eblen, a general practitioner at Henderson, was graduated from the University of Louisville School of Medicine in 1948. He has been an active member of the Kentucky Academy of General Practice, and for the past six years has been a member of the Board of Directors of the KAGP for District Two. Doctor Eblen has also served as a delegate to the Kentucky Medical Association from the Henderson County Medical Society. He is a member of the American Society of Anesthesiologists, the Southern Medical Association, as well as KMA and AMA.

KMA Secretary and Treasurer

SECRETARY

Henry B. Asman, M.D., Louisville



In 1963 Doctor Asman, a 1936 graduate of the University of Louisville School of Medicine, succeeded Woodford B. Troutman, M.D., as secretary of the KMA. He is a former vice-president (1961-62) of the Association, and a past president of the Kentucky Division of the American Cancer Society. Doctor Asman is a Fellow of the American College of Surgeons and the Southeastern Surgical Congress. He served in the U.S. Army Medical Corps during World War II, from 1942 to 1946, and was discharged with the rank of Lieutenant Colonel.

TREASURER

Keith P. Smith, M.D., Corbin



Doctor Smith, who was elected treasurer of the Kentucky Medical Association in 1963, has been active in KMA affairs for many years. From 1957 until elected to his current post, he served as KMA trustee (then councilor) from the Fifteenth District, and in 1962-63 was chairman of the Board of Trustees. He has served as a KMA vice-president and is a former president and vice-president of the Kentucky Chapter of the American Academy of General Practice. He is a 1936 graduate of the University of Louisville School of Medicine.

KMA Journal Editors

EDITOR

Sam A. Overstreet, M.D., Louisville



Doctor Overstreet, who served as president of KMA during the Centennial years of 1950-51, has been editor of The Journal for seven years. He had previously been scientific editor. He was graduated in 1923 from the University of Louisville School of Medicine, where he now holds the position of clinical professor of medicine. Doctor Overstreet, a former president of the Jefferson County Medical Society, is also a former speaker of the KMA House of Delegates and a past governor of the KentuckyChapter, American College of Physicians.

ASSOCIATE EDITOR

Walter S. Coe, M.D., Louisville



Doctor Coe, who was book review editor of The Journal for many years, was named associate editor in 1962. He is an associate clinical professor of medicine on the faculty of the University of Louisville School of Medicine, where he received his medical degree in 1943. He is currently president of the Kentucky Heart Association, and has served as a director of that organization. He is also a past president of the Louisville and Jefferson County Heart Association and of the Kentucky Society of Internal Medicine.

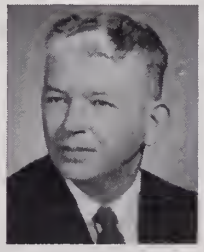
AMA Delegates

Wyatt Norvell, M.D., New Castle



The senior delegate from KMA to the American Medical Association, Doctor Norvell, was elected to his current post in 1962. Prior to that time he had served as chairman of the Board of Trustees of KMA and as a vice-president (Eastern). He was for several years Trustee from the Seventh District and has been chairman of the Committee on Rural Health and a member of the KMA Memorials Commission. He is a former director of the KAGP.

J. Thomas Giannini, M.D., Louisville



Doctor Giannini, who was elected a delegate from KMA to the AMA in 1963, previously served in the Association as an alternate delegate and as chairman of the Scientific Exhibits Committee. A 1938 graduate of the University of Louisville School of Medicine, he served in the U.S. Navy Medical Corps as a Captain from 1942-1954. Doctor Giannini, who limits his practice to plastic and reconstructive surgery, is a Fellow of the American Society of Plastic and Reconstructive Surgeons.

AMA Delegate

John C. Quertermous, M.D., Murray



Doctor Quertermous, currently chairman for national affairs of the KMA Council on Legislative Activities, served as an alternate delegate to the AMA until being elected delegate in 1963. An internist, he has also served KMA as a member of its Committee on Aging, and the Committee on Postgraduate Medical Education. He is a past president of the Calloway County Medical Society and in 1960 served on the Governor's Citizens Committee on Problems of Aging. Doctor Quertermous, who graduated in 1942 from the University of Louisville School of Medicine, served in the Army Medical Corps from 1943 to 1946.

New Trustees

W. Gerald Edds, M.D., Calhoun

A graduate of the University of Louisville School of Medicine in the class of 1950, Doctor Edds has been a general practitioner in McLean County since 1951. Prior to that time he served during World War II in the U.S. Navy and for one year as principal of Alvaton High School. Doctor Edds was made chairman of the McLean County Board of Health in 1953 and was instrumental in the establishment of the McLean County Hospital in 1957. He is a former member of the Calhoun City Council and a past president of the local Lions Club, in addition to active participation in church work. In 1964 he was appointed by Governor Edward T. Breathitt to a four year term on the Board of Regents of Western Kentucky State College.

Walter L. Cawood, M.D., Ashland

A native of Lena Rue, Harlan County, Doctor Cawood attended Berea College, Eastern Kentucky State College, and the University of Kentucky before he was graduated in 1946 from the University of Louisville School of Medicine. Following an internship in Nashville he served from 1947-49 with the Army Medical Corps, and upon his discharge began general practice in Harlan, which he continued until 1955. Following residency training at Johns Hopkins Hospital, Doctor Cawood entered the practice of radiology at Ashland. He is active in the Boyd County Medical Society and has served in a number of capacities in KMA. He is a member of the American College of Radiology.

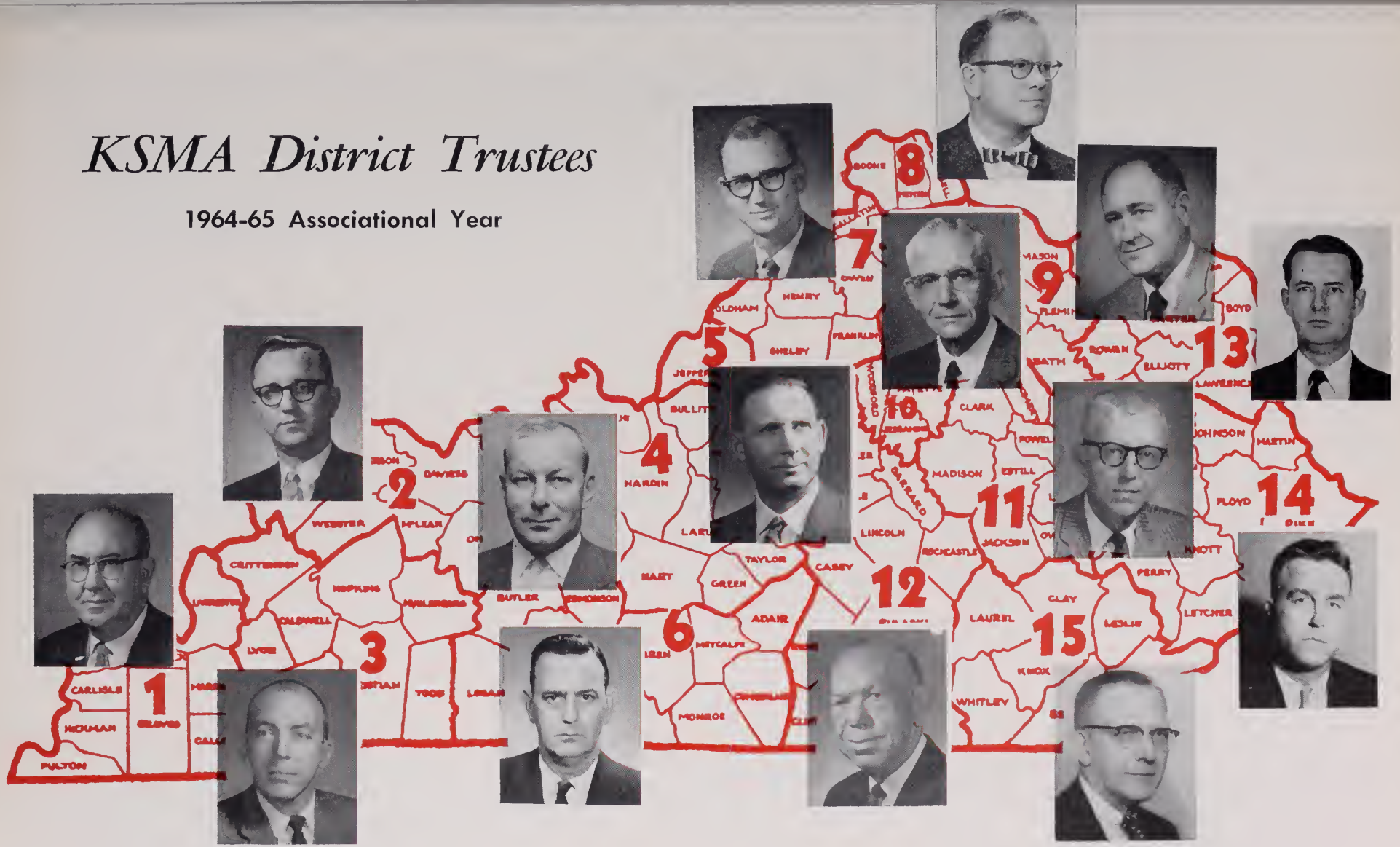
Election of Trustees

Five KMA District Trustees will be elected by the House of Delegates at its second session on Wednesday, September 22. Immediately after the first session of the House on September 20, nominations will be made at a caucus of the delegates from each district. At the close of the first scientific session on Tuesday, September 21, the committee will report its nominees. Further nominations may be made from the floor at the second meeting of the House on September 22. Districts electing new trustees are: **First District:** (incumbent, O. Leon Higdon, M.D., Paducah); **Third District:** (incumbent, Gabe A. Payne, M.D., Hopkinsville); **Fourth District:** (incumbent, Dixie E. Snider, M.D., Springfield); **Twelfth District:** (incumbent, Thomas O. Meredith, M.D., Harrodsburg); and **Fourteenth District:** (incumbent, William C. Hambley, M.D., Pikeville. Doctors Higdon and Payne have served only one full term and are eligible for re-election. Biographical information on trustees elected in 1964 appears above.

see map on following page

KSMA District Trustees

1964-65 Associational Year



1. O. LEON HIGDON, Paducah
2. W. GERALD EDDS, Calhoun
3. GABE A. PAYNE, JR., Hopkinsville
4. DIXIE E. SNIDER, Springfield
5. ALFRED O. MILLER, Louisville
6. REX E. HAYES*, Glasgow
7. DONALD CHATHAM, Shelbyville
8. W. DONALD JANNEY, Covington
9. MITCHEL B. DENHAM, Maysville
10. DOUGLAS E. SCOTT, Lexington
11. HUBERT C. JONES*, Berea
12. THOMAS O. MEREDITH, Harrodsburg
13. WALTER L. CAWOOD, Ashland
14. WILLIAM C. HAMBLEY, Pikeville
15. ROBERT C. PENNINGTON †, London

†*Chairman of the Board*
**Member of the Executive Committee*

Officers of the KMA House of Delegates

SPEAKER

Garnett J. Sweeney, M.D., Liberty



Doctor Sweeney was named speaker of the House in 1962 after serving since 1959 as vice-speaker. Before that time he was chairman of the KMA Council (now the Board of Trustees), having served for two terms as councilor from the Twelfth District. Doctor Sweeney was graduated in 1939 from the University of Louisville School of Medicine. In 1954 he was president of the Kentucky Chapter of the American Academy of General Practice. He has served as a member of the Board of Directors of Kentucky Physicians Mutual, Inc. (Blue Shield), and a member of the KMA Advisory Commission to Blue Shield.

VICE-SPEAKER

George F. Brockman, M.D., Greenville



Doctor Brockman, elected to his current office in 1962, has served as a member of several KMA committees, among them the committees on Maternal Mortality, Scientific Assembly, and Public Education. He was chairman of the KMA Building Committee, which directed the planning and construction of the Headquarters Office. He is also former chairman of the Advisory Committee to the Editor of The Journal. He was appointed delegate to the AMA in April, 1961 and served until the end of that year. A 1935 graduate of the U. of L. School of Medicine, Doctor Brockman is secretary of the Muhlenberg County Medical Society.

KMA Delegates

ADAIR
Oris Aaron, Columbia

ALLEN
Earl P. Oliver, Scottsville

ANDERSON
Boyd Caudill, Lawrenceburg

BALLARD
Glenn Baird, Bandana

BARREN
W.H. Bryant, Glasgow

BATH

BELL
C.B. Stacey, Pineville
M.J. Evans, Middlesboro

BOONE
Lee Hess, Florence

BOURBON
James E. Ferrell, Paris

BOYD
Rex Duff, Ashland
J.E. Stephenson, Ashland
John Ashworth, Ashland

BOYLE
Chris S. Jackson, Sr., Danville

BRACKEN
J.M. Stevenson, Brooksville

BREATHITT
F.C. Lewis, Jackson

BRECKINRIDGE
James G. Sills, Hardinsburg

BULLITT
R.S. Bowen, Mt. Washington

BUTLER
John C. Burris, Morgantown

CALDWELL
Ralph L. Cash, Princeton

CALLOWAY
C.C. Lowry, Murray

CAMPBELL-KENTON
Richard A. Allnutt, Covington
Carl Brueggemann, Covington
Ronald Fragge, Covington
W.V. Pierce, Covington
Paul Klingenberg, Covington
Robert Longshore, Covington
J.R. Stevie, Covington

CARLISLE

CARROLL
E.S. Weaver, Carrollton

CARTER

CASEY

CHRISTIAN
Guinn S. Cost, Hopkinsville
Norma T. Shepherd, Hopkinsville

CLARK
Thomas E. Averitt, Winchester

CLAY
W.E. Becknell, Manchester

CLINTON
Ernest A. Barnes, Albany

CRITTENDEN
R. M. Brandon, Marion

CUMBERLAND
Robert B. Chambliss, Burkesville

DAVIESS
J.H. Kurre, Owensboro

EDMONSON
S. E. Farmer, Brownsville

ELLIOTT
John F. Greene, Sandy Hook

ESTILL
Raymond R. Snowden, Ravenna

FAYETTE
M.R. Gilliam, Lexington
Robert D. Shepard, Lexington
Joseph H. Saunders, Lexington
David B. Stevens, Lexington
Thomson R. Bryant, Jr., Lexington
Richard D. Floyd, Lexington
Carl H. Fortune, Lexington
David A. Hull, Lexington
Graydon A. Long, Lexington
Andrew M. Moore, Lexington
Irving F. Kanner, Lexington
N.L. Bosworth, Lexington

FLEMING
R.W. Fidler, Flemingsburg

FLOYD
R.L. Hall, Prestonsburg

FRANKLIN
John P. Stewart, Frankfort
Harry J. Cowherd, Frankfort

FULTON
R.W. Bushart, Fulton

GALLATIN

GARRARD
O.S. Playforth, Lancaster

GRANT
Daryl B. Shipp, Dry Ridge

GRAVES
John Reed, Mayfield

GRAYSON
Ralph G. Thomas, Leitchfield

GREEN
Kenneth J. S. DeSimone, Greensburg

GREENUP
Ted Sanders, Flatwoods

HANCOCK
B. P. Smith, Hawesville

HARDIN
Fred C. Rainey, Elizabethtown

HARLAN
Henry C. Evans, Harlan
Doane Fischer, Harlan

HARRISON
Henry H. Moody, Cynthiana

HART

HENDERSON

HENRY
Shelby Hicks, New Castle

HICKMAN
V.A. Jackson, Clinton

HOPKINS
L.C. Trover, Earlington
F.A. Scott, Madisonville

JACKSON

JEFFERSON
Frank A. Bechtel, Louisville
Elbert G. Christian, Louisville
Morgan R. Colbert, Louisville
William C. Durham, Louisville
Rudy J. Ellis, Louisville
Hollis Johnson, Louisville
George F. McAuliffe, Louisville
Samuel M. Smith, Louisville
Robert C. Tate, Louisville
W.C. Gettelfinger, Louisville
Edward Warrick, Jr., Louisville
McHenry Brewer, Louisville
Sam Black, Louisville
John Doyle, Louisville
Robert McClendon, Louisville
Henry Post, Louisville
W. Fielding Rubel, Louisville
William Rumage, Jr., Louisville
William Stodghill, Louisville
John Wolford, Louisville,
Eugene Conner, Louisville
Louis Foltz, Louisville
Richard Greathouse, Louisville
John Harter, Louisville
Walter I. Hume, Jr., Louisville
Herman Moore, Louisville
Clyde Moore, Louisville
Gerald Peterson, Louisville
George Sehlinger, Louisville
Sam Weakley, Louisville

JESSAMINE
J.S. Williams, Nicholasville

JOHNSON
Ernest Skaggs, Paintsville

KNOTT
M. F. Kelley, Hindman

KNOX
H.L. Bushey, Barbourville

LARUE
Marion Douglass, Magnolia

LAUREL
E.C. Seeley, London

LAWRENCE
A.B. Richards, Louisa

LEE

LETCHER
T.M. Perry, Jenkins

LESLIE

LEWIS

LINCOLN
H.I. Frisbie, Stanford

LIVINGSTON

LOGAN
C.V. Dodson, Russellville

LYON
James E. Hamilton, Eddyville

McCRACKEN
James Harris, Paducah
W. B. Haley, Paducah
R.M. Wooldridge, Paducah

McCREARY

McLEAN
Everett Coleman, Sacramento

MADISON
Douglas Jenkins, Richmond
Dwight L. Blackburn, Richmond

MAGOFFIN

MARION
David D. Drye, Bradfordsville

MARSHALL
Joe R. Miller, Benton

MARTIN
John W. Ford, Inez

MASON

MEADE
George E. Clark, Brandenburg

MENIFEE
D.L. Graves, Frenchburg

MERCER
J.S. Baughman, Harrodsburg

METCALFE
P.D. Hitchcock, Edmonton

MONROE
John A. Marsh, Gamaliel

MONTGOMERY
R.J. Salisbury, Mt. Sterling

MORGAN
Morris Peyton, West Liberty

MUHLENBERG
R. E. Davis, Central City

NELSON
William Yates, Bloomfield

NICHOLAS
W.R. Kingsolver, Carlisle

OHIO
George S. Beard, Hartford

OLDHAM

OWEN
O.A. Cull, Owenton

OWSLEY
M.B. Gabbard, Booneville

PENDLETON
Robert L. McKenney, Falmouth

PERRY
E.S. Carter, Hazard

PIKE
B.W. Cassady, Pikeville

POWELL
C.G. Noss, Stanton

PULASKI
A.L. Cooper, Somerset
B. L. Ramsey, Jr., Somerset

ROBERTSON

ROCKCASTLE
Jack Lewis, Mt. Vernon

ROWAN
S. E. Reynolds, Morehead

RUSSELL
David L. Lawrence, Jamestown

SCOTT
J.C. Cantrill, Georgetown

SHELBY
W.P. McKee, Shelbyville

SIMPSON
L.F. Beasley, Franklin

SPENCER
M. H. Skaggs, Taylorsville

TAYLOR
Henry F. Chambers, Jr., Campbellsville

TODD
R.D. Lynn, Elkton

TRIGG
Thornton Bryan, Jr., Cadiz

TRIMBLE
Carl Cooper, Jr., Bedford

UNION

WARREN
Martin Wilson, Bowling Green
Paul Parks, Bowling Green

WASHINGTON
H. B. Simms, Springfield

WAYNE
John W. Simmons, Monticello

WEBSTER
John A. Logan, Sebree

WHITLEY
Harold Barton, Corbin

WOLFE
Paul F. Maddox, Campton

WOODFORD
Francis Willey, Versailles

Reference Committee Activity

At the first meeting of the KMA House of Delegates at 9 a.m. on Monday, September 20, Speaker Garnett J. Sweeney, M.D., Liberty, will refer all officers' and committee reports and resolutions to one of seven reference committees. Reference committees will meet at **2 p.m. on Monday, September 20** on the mezzanine floor of the Kentucky Hotel. Members of the committees will meet for briefing sessions at 12:30 Monday in Parlor B at the Kentucky. **Any KMA member wishing to testify on any resolution or report is urged to be present at 2 p.m.** In order to permit all who wish to speak to be heard, the open hearings will last at least an hour. Following the open hearings, the committee will go into executive session to study the reports, review the testimony and write its report to the House.

The committees' recommendations will be made for presentation **at the final session of the House in the Terrace Room of the Kentucky on Wednesday night, September, 22.** Reference committees appointed by Doctor Sweeney to serve during the 1965 session are listed below.

1965 Reference Committee Appointments

REFERENCE COMMITTEE NO. 1
Reports of Officers and Board of Trustees

Robert T. Longshore, M.D., Covington, Chairman
Thomson R. Bryant, M.D., Lexington
Joseph H. Kurre, M.D., Owensboro
Mary Pauline Fox, M.D., Hazard
Paul J. Ross, M.D., Louisville

REFERENCE COMMITTEE NO. 2
Scientific Assembly and Medical Education

E. C. Seeley, M.D., London, Chairman
Eugene H. Conner, M.D., Louisville
W. B. Haley, M.D., Paducah
Paul J. Parks, M.D., Bowling Green
J. Sankey Williams, M.D., Nicholasville

REFERENCE COMMITTEE NO. 3
Legislative Activities

Fred C. Rainey, M.D., Elizabethtown, Chairman
Richard F. Greathouse, M.D., Louisville
M. C. Loy, M.D., Columbia
James G. Sills, M.D., Hardinsburg
David B. Stevens, M.D., Lexington

REFERENCE COMMITTEE NO. 4
Public Service and Allied Professions

Andrew M. Moore, M.D., Lexington, Chairman
W. E. Becknell, M.D., Manchester
P. D. Hitchcock, M.D., Edmonson
Walter I. Hume, Jr., M.D., Louisville
John M. Reed, M.D., Mayfield

REFERENCE COMMITTEE NO. 5
Medical Service

George A. Sehlinger, M.D., Louisville, Chairman
George S. Beard, M.D., Hartford
Walter L. Boswell, M.D., Lexington
James L. Ferrell, M.D., Paris
J. E. Stephenson, M.D., Ashland

REFERENCE COMMITTEE NO. 6
Constitution and Bylaws; Special Committees

Douglas Jenkins, M.D., Richmond, Chairman
James S. Baughman, M.D., Harrodsburg
LeRoy C. Hess, M.D., Florence
Joseph R. Miller, M.D., Benton
Henry W. Post, M.D., Louisville

REFERENCE COMMITTEE NO. 7
Miscellaneous

Samuel D. Weakley, M.D., Louisville, Chairman
Harry F. Cowherd, M.D., Frankfort
Ronald Fragge, M.D., Covington
C. C. Lowry, M.D., Murray
Robert J. Salisbury, M.D., Mt. Sterling

Open Meeting Planned Monday By Nominating Committee

Members wishing to confer with the KMA Nominating Committee will have the opportunity to do so at an open meeting (location to be announced) scheduled to follow the close of the first session of the House of Delegates on Monday morning, September 20.

Final recommendations of the Committee will be reported at the end of the first scientific session on Tuesday morning, September 21. Other nominations may be made from the floor at the House of Delegates meeting on Wednesday evening, September 22. At the close of the second session on Wednesday, the House will vote on the nominees.

Members of the Nominating Committee, headed by Harold B. Barton, M.D., Corbin, are: Carl H. Fortune, M.D., Lexington; Russell L. Hall, M.D., Prestonsburg; James M. Riley, M.D., Louisville; and Paul J. Sides, M.D., Lancaster.



The Kentucky Hotel
KMA Annual Meeting Headquarters

Annual Meeting Special Features

SCIENTIFIC SESSIONS are scheduled daily on September 21, 22, and 23 at the Convention Center in Louisville. Features of the program will include a telephone party line conference on Arteriosclerotic Heart Disease, panel discussions on Peptic Ulcer and Respiratory Distress in the Newborn, as well as outstanding individual presentations.

SEVENTY-FIVE TECHNICAL EXHIBITS featuring the latest developments in medical equipment, pharmaceutical products and literature will be presented at the 1965 Annual Meeting. Thirty-minute intermissions have been scheduled during each general and specialty group session for your convenience in visiting these informative and interesting displays.

THE HOUSE OF DELEGATES, the policy-making body of KMA, will be in session twice during the Annual Meeting. The first session will be held Monday morning, September 20 at 9:00 a.m. The House will meet for the second time Wednesday evening, September 22, at 7:00 p.m. Both sessions will be held in the Terrace Room of the Kentucky Hotel. Officers for 1965-66 will be elected at the Wednesday evening session.

SIXTEEN SPECIALTY GROUPS will meet on two days. Eight will meet on Tuesday afternoon, September 21, and eight on Thursday, September 23. No general sessions have been scheduled for those afternoons. All KMA members are invited to attend any of these meetings. Guest lecturers representing a variety of medical specialties are scheduled to address the individual groups.

THE PRESIDENT'S LUNCHEON will be held again this year in the Terrace Room of the Kentucky Hotel, at 11:50 a.m. Wednesday, September 22. Philip M. Crane, Ph.D., assistant professor of history at Bradley University, will discuss "The American Dilemma". Doctor Crane is nationally known as a speaker and historian. Presentation of KMA's three top awards will be made at the luncheon.

ALUMNI REUNIONS, a tradition at KMA Annual Meetings, will be held again this year. A moonlight cruise on the Belle of Louisville, scheduled for Tuesday evening, will be held for alumni of the University of Louisville School of Medicine. A buffet supper will be served on board, and Jeannie Crume and her orchestra will provide music for dancing. Reservations will be limited to 600 persons.

OFFICIAL CALL

KMA Annual Meeting

To the officers and members of the component county medical societies of the Kentucky State Medical Association.

Meeting Place

The Annual Meeting of the KMA will convene at the Convention Center, Louisville, on Tuesday, Wednesday, and Thursday, September 21, 22, and 23. The first general session will be called to order at 8:50 a.m. Tuesday.

The House of Delegates

The first regular session of the House of Delegates will convene at 9:00 a.m. Monday, September 20. The second regular business session will begin at 7:00 p.m. Wednesday, September 22. Both sessions will be held in the Terrace Room of the Kentucky Hotel.

Registration

The registration desk will open at the Terrace Room on the fourth floor of the Kentucky Hotel at 8:00 a.m. Monday, September 20, and at 5:30 p.m. Wednesday September 22. It will be open in the technical exhibit hall of the Convention Center from 8:00 a.m. to 5:00 p.m. on Tuesday, September 21; Wednesday, September 22; and Thursday, September 23.

Annual Meeting Woman's Auxiliary to the KMA

Tuesday, September 21

Pre-convention Board Breakfast (subscription): 8:00 AM, Parlor B, Kentucky Hotel. All general officers, chairmen of standing and special committees, three immediate past presidents, councilors, co-ordinator for Members-at-large, and the county auxiliary presidents are urged to attend.

Formal Opening of Convention: 10:00 AM, Mirror Room, Kentucky Hotel

Luncheon (subscription) honoring past presidents, members-at-large, and distinguished guests: 12:30 PM, Parlors B and C

Formal Convention Session: 2:00 PM, Mirror Room

Wednesday, September 22

Formal Convention Session: 9:15 AM, Mirror Room, Kentucky Hotel

Luncheon-Fashion Show (subscription) honoring Mrs. Asher Yaguda, President-elect, Woman's Auxiliary to the AMA: 12:30 PM, Flag Room

Gavel Club Dinner for Past State Presidents: 7:00 PM

Thursday, September 23

Post-convention Board Breakfast (subscription): 8:45 AM, Parlor A

Dr. Crane to be Featured Speaker At 1965 President's Luncheon

"The American Dilemma" will be discussed by Doctor Philip Crane, Bradley University professor, as the top feature of the 1965 KMA President's Luncheon to be held at the Kentucky Hotel Wednesday, September 22.



Doctor Crane

"A relative newcomer to the 'banquet circuit', this young political analyst and modern historian brings a fresh and penetrating discussion of the acute situation this country faces today", said Delmas M. Clardy, M.D., KMA president, in making the announcement. "I think we are most fortunate to get Doctor Crane and we will all be most pleased with him."

Before going to Bradley, where he is now assistant professor of history, Doctor Crane taught at Indiana University for three years. He received his M.A. and Ph.D. degrees from I.U., and in addition did post-graduate work at the University of Michigan and the University of Vienna.

Newly listed in *Who's Who in American Education,* he is the author of the book, *The Democrat's Dilemma,* which traces the growth of the Fabian Socialist movement in American politics since 1905.

He is on the editorial Advisory Board of *The Intercollegiate Review* and is a member of the American Historical Association, the Organization of American Historians, Phi Alpha Theta (history honorary), the Philadelphia Society, and the National Institute of Social Sciences, as well as others.

Doctor Crane will speak following the luncheon which begins at 11:50 a.m. in the Terrace Room of the Kentucky.

Please Take This Issue Home

Your wife may be interested in the special features presented in this issue of The Journal. In addition to the full program of her own meeting of The Woman's Auxiliary to KMA, she will enjoy reading of the activities planned for the regular KMA Annual Meeting. KMA President Delmas M. Clardy, M.D. urges that you carry this issue home to your wife for her information and enjoyment.

REGISTRATION

Please register at the Registration Booth in the north end of the Convention Hall (in the Technical Exhibit Hall) as soon as you are able. Hours are from 8:00 a.m. to 5:00 p.m. Tuesday, Wednesday, and Thursday, September 21, 22, and 23.

You are requested to wear your badges at all times while attending the meeting.

1965 Annual Meeting Program Summary

The Kentucky Medical Association

September 19, 20, 21, 22 and 23

Louisville

SUNDAY, SEPTEMBER 19

12:30 p.m.	Luncheon Meeting, KMA Board of Trustees	Parlor A, Kentucky Hotel
6:30 p.m.	Dinner Meeting, Board of Directors, Ky. Physicians Mutual	Ship Room, Kentucky Hotel

MONDAY, SEPTEMBER 20

8:30 a.m.	Orientation Program, New KMA Members	Mirror Room, Kentucky Hotel
9:00 a.m.	First Meeting, KMA House of Delegates	Terrace Room, Kentucky Hotel
12:30 p.m.	Luncheon for Reference Committee Chairmen	Room 317, Kentucky Hotel
2:00 p.m.	Reference Committee Meetings	Parlors A, B, C, D—Rooms 203, 4 & 5, Kentucky Hotel
6:00 p.m.	KEMPAC Reception, Banquet and Seminar	Flag Room, Kentucky Hotel

TUESDAY, SEPTEMBER 21

8:00 a.m.	Registration	Technical Exhibit Hall, Convention Center
8:50 a.m.	Opening Ceremonies	Scientific Assembly Hall, Convention Center
9:00 a.m.	First Scientific Session	Scientific Assembly Hall, Convention Center
2:00 p.m.	Specialty Group Sessions, Convention Center *(Eight Specialty Group Sessions will be held simultaneously at this time. Any KMA member mayattend any of these meetings. There will be no General Session at this time. See pages 599 & 600 in program.)*	
3:00 p.m.	Meeting of County School Health Chairmen	Room 207, Convention Center
5:30 p.m.	U. of L. Medical Alumni Cruise and Reunion	Belle of Louisville, Fourth Street Dock

WEDNESDAY, SEPTEMBER 22

9:00 a.m.	Second Scientific Session	Scientific Assembly Hall, Convention Center
11:50 a.m.	President's Luncheon	Terrace Room, Kentucky Hotel
2:00 p.m.	Telephone Party Line Conference	Scientific Assembly Hall, Convention Center
5:00 p.m.	Meeting, Board of Trustees	Parlor B—Dinner at 6:00, Parlor A, Kentucky Hotel
6:00 p.m.	Subscription Dinner and Meeting, House of Delegates	Terrace Room, Kentucky Hotel

THURSDAY, SEPTEMBER 23

9:00 a.m.	Fourth Scientific Session	Scientific Assembly Hall, Convention Center
12:00 noon	Board of Trustees Luncheon and Afternoon meeting	Parlor A, Kentucky Hotel
2:00 p.m.	Specialty Group Sessions, Convention Center *(Eight Specialty Group Sessions will be held simultaneously at this time. Any KMA member may attend any of these meetings. There will be no General Session. See pages 602 & 603 in program.)*	

A 30-minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting Scientific and Technical Exhibits.

(Full Scientific Program starts on page 598).

The Kentucky State Medical Association

SCIENTIFIC PROGRAM

Pinckney Thompson Memorial Meeting

Convention Center, Louisville

TUESDAY, SEPTEMBER 21

MORNING SESSION

General Session

Delmas M. Clardy, M.D., Hopkinsville, KMA President, Presiding

8:50 **Opening Ceremonies**
Welcome—Roy H. Moore, Jr., M.D., Louisville, Ky.
Invocation—The Reverend Leslie H. Woodson, Beechmont Methodist Church, Louisville, Ky.

9:00 **"Mechanical Aids to Respiration"**
Hurley L. Motley, M.D., Los Angeles, Calif.

9:20 **"Pathogenesis of Respiratory Distress"**
Edith L. Potter, M.D., Chicago, Ill.

9:40 **"The Diagnosis and Therapy of Hemorrhagic Disorders Occurring During Surgery"**
William S. Howland, M.D., New York, N.Y.

10:00 **Visit Exhibits**

10:30 **President's Address**
Delmas M. Clardy, M.D., Hopkinsville, Ky.

10:50 **Panel Discussion: "Respiratory Distress in the Newborn"**
Walter T. Hughes, M.D., Louisville, Ky. Moderator
J. W. Greene, Jr., M.D., Lexington, Ky.
Hurley L. Motley, M.D., Los Angeles, Calif.
Edith L. Potter, M.D., Chicago, Ill.
Mildred Stahlman, M.D., Nashville, Tenn.

Lunch — 12:00 Noon

TUESDAY, SEPTEMBER 21

AFTERNOON SESSION

Specialty Group Meeting

(There will be no General Scientific Session on Tuesday Afternoon. Eight Specialty Groups will meet at that time. All KMA members are cordially invited to attend any of these meetings.)

HURLEY L. MOTLEY, M.D.
Los Angeles, Calif.



Professor of medicine and director of the cardio-respiratory laboratory, University of Southern California School of Medicine. Former associate professor of medicine and director of cardio-respiratory laboratory, Jefferson Medical College, and former associate professor of physiology and pharmacology, University of Missouri Medical School. Graduate Harvard Medical School, 1936. Fellow, American College of Physicians, American College of Chest Physicians; member, American Physiological Society, AMA, and others. Citation of Merit in Medicine, University of Missouri Alumni Association, 1960.

EDITH L. POTTER, M.D.
Chicago, Ill.

Professor of pathology, department of obstetrics and gynecology, University of Chicago School of Medicine; formerly instructor, assistant professor and associate professor of pathology at the University of Chicago. Received M.D. from University of Minnesota School of Medicine in 1926; holder of masters degrees in science and philosophy from University of Minnesota. Member, American Association of Pathologists and Bacteriologists, American College of Obstetrics and Gynecology, American Academy of Pediatrics and many others. President in 1944 of Chicago Pathological Society.



WILLIAM S. HOWLAND, M.D.
New York, N.Y.



Head of the section of experimental anesthesiology and associate in the Sloan-Kettering Institute, New York City. Graduate, 1944, Columbia University College of Physicians and Surgeons. Former assistant professor of anesthesiology, Columbia University and former associate professor of surgery at Cornell University Medical College. President-elect of the New York State Society of Anesthesiologists; current chairman and former secretary of the New York Academy of Medicine; chairman, 1962, of Anesthesiology Section of the N.Y. State Society of Medicine.

Kentucky Society of Anesthesiologists

Room 203 — Convention Center

2:00 "Bronchoscopy and Bronchography Under General Anesthesia"
Lewis Francis, M.D., Lexington, Ky.

2:30 To be Announced—

3:00 Visit Exhibits

3:30 Topic to be Announced—
William S. Howland, M.D., New York, N.Y.

4:00 Business Meeting

Kentucky Chapter, American College of Chest Physicians

Room 104 — Convention Center

2:00 Fireside Conferences on the Following Topics:
Clinical Cardiology Including Surgery
Electrocardiography and Vectercardiography
Tuberculous and Fungus Diseases (Thoracic)
Pulmonary Physiology
Allergy
Thoracic Surgery

3:00 Visit Exhibits

3:30 Resume Fireside Conferences

Kentucky Industrial Medical Association

Room 205 — Convention Center

2:00 "The Emotional Climate of the Company"
Alan A. McLean, M.D., Armonk, N. Y.

3:00 Visit Exhibits

3:30 "Noise-Induced Hearing Loss—Its Detection, Diagnosis and Prevention"
Gerald D. Landau, M.D., Louisville, Ky.
William J. Brown, Ph.D., Lousville, Ky.

Kentucky Orthopaedic Society

Room 204 — Convention Center

2:00 "Surgery and Cerebral Palsy"
Boone Brackett, M.D., Lexington, Ky.
Eugene Q. Parr, M.D., Lexington, Ky.

2:40 "Nutrition of Articular Cartilage"
Thomas D. Brower, M.D., Lexington, Ky.

3:00 Visit Exhibits

3:30 "Roentgengraphic Interpretation of the Lumbar Spine"
Samuel O. Hodges, M.D., Lexington, Ky.

3:50 "Discograms and Lumbar Disc Disease"
W. K. Massie, M.D., Lexington, Ky.
David B. Stevens, M.D., Lexington, Ky.

4:10 "Management of Fractures Resulting from Civilian Missiles"
Narayan P. DebRoy, M.D., Louisville, Ky.
Darius Ghazi, M.D., Louisville, Ky.
Richard B. Welch, M.D., Louisville, Ky.

Kentucky Obstetrical and Gynecological Society

Assembly Hall — Convention Center

2:00 "Radical Surgery for Cervical Carcinoma"
Clayton T. Beecham, M.D., Danville, Pa.

3:00 Visit Exhibits

3:30 Open Meeting with the Maternal Mortality Study Committee of KMA.

MILDRED STAHLMAN, M.D.
Nashville, Tenn.

Assistant professor of pediatrics, Vanderbilt University School of Medicine and former assistant professor of physiology at Vanderbilt. Graduated 1946 from Vanderbilt School of Medicine. Member of Society for Pediatric Research, Southern Society for Pediatric Research, Southern Society for Clinical Research, Middle Tennessee Heart Association (former member of the Board of Directors); member and former president of Southern Society of Pediatric Research; member Nashville Pediatric Society, American Federation for Clinical Research. Lederle Medical Faculty Award, 1961-1962; U.S. Public Health Service Career Development Award, 1963-1964.



ALAN A. MCLEAN, M.D.
Armonk, N.Y.



Psychiatric consultant for the International Business Machines Corporation since 1957. Also assistant visiting neuropsychiatrist at Bellevue Hospital, assistant attending psychiatrist at New York University Medical Center and Hospital, and program director of the Center of Occupational Mental Health, Inc. Previously consulting psychiatrist for the New York Telephone Company, American Cyanamid Company, and General Electric. Former faculty member at the Universities of Washington, Oregon and Cornell Medical Schools. Fellow of American Psychiatric Association and chairman of its committee an occupational psychiatry.

THOMAS D. BROWER, M.D.
Lexington, Ky.

Professor of orthopedic surgery at the University of Kentucky Medical center and consultant at the Lexington Veterans Administration Hospital. On attending staffs of Shriners Crippled Childrens' Hospital, Goad Samaritan and St. Joseph's Hospitals. Member Interstate Orthopedic Society, Arthritis and Rheumatism Association, Orthopedic Research Society, American Academy of Orthopedic Surgery. Former staff member at the University of Chicago and M.D., 1947, Washington University, St. Louis.



CLAYTON T. BEECHAM, M.D.
Danville, Pa.



Director of gynecology and obstetrics at the Geisinger Medical Center, Danville. Graduated in 1932 from the University of Minnesota Medical Sschool. Secretary of the American Association of Obstetricians and Gynecologists. Chairman, District III, The American College of Obstetricians and Gynecologists. Member of the Society of Pelvic Surgeons and the American College of Surgeons. Former instructor of obstetrics at the University of .Pennsylvania. Former clinical professor of obstetrics and gynecology at Temple University.

Kentucky Society of Pathologists

Room 206 — Convention Center

1:30 "The Interpretation of Glucose Tolerance Test"
Edward J. Fadell, M.D., Louisville, Ky.
William B. Stodghill, M.D., Louisville, Ky.

2:00 "Abnormal Development of the Ovary as it May Affect Ovarian Function in the Adult"
Edith L. Potter, M.D., Chicago, Ill.

2:30 "The Role of the Gastric Secretion in the Absorption of Iron"
John A. Koepke, M.D., Lexington, Ky.

3:00 Visit Exhibits

3:30 "Metastasis of Benign Lesions"
Logan Mahaffey, M.D., Louisville, Ky.

4:00 "The Causes of Death in a Large State Mental Hospital"
Elton Heaton, M.D., Louisville, Ky.

Kentucky Chapter, American Academy of Pediatrics

Room 101 — Convention Center

2:00 "Cardiovascular Assessment of Infants with Hyaline Membrane Disease"
Mildred Stahlman, M.D., Nashville, Tenn.

3:00 Visit Exhibits

3:30 "The Diagnosis and Treatment of Urinary Tract Infections in Children"
Nancy Holland, M.D., Lexington, Ky.

Kentucky Urological Association

Room 208 — Convention Center

2:00 "Various Types of Urinary Diversion — Pros and Cons"
Richard Chute, M.D., Brookline, Mass.

3:00 Visit Exhibits

3:30 Program Presentation
Robert Lich, Jr., M.D., Louisville, Ky., and Edward H. Ray, M.D., Lexington, Ky., Moderators

WEDNESDAY, SEPTEMBER 22

MORNING SESSION

General Session

Robert W. Lykins, M.D., Louisville
Vice-President (Central) Presiding

9:00 "Surgical Treatment of Osteo Arthritis of the Hip"
Thomas D. Brower, M.D., Lexington, Ky.

9:20 "Bacteriuria and Pyelonephritis"
Richard Chute, M.D., Brookline, Mass.

9:40 "Prevention of Serious Injuries—Mouthguards for Athletes"
Theodore E. Logan, D.M.D., Louisville, Ky.

10:00 Visit Exhibits

10:30 "Your Psychiatric Patient at Work"
Alan A. McLean, M.D., Armonk, N.Y.

10:50 "Management of Endometriosis"
Clayton T. Beecham, M.D., Danville, Pa.

11:10 Presentation of Scientific Exhibit Award

RICHARD CHUTE, M.D.

Brookline, Mass.



Clinical professor of urology, Boston University School of Medicine. Since 1944 chief of the section of urology at Boston Veterans Administration Hospital. Graduated from Harvard Medical School in 1927. Fellow of the American College of Surgeons; Diplomate, American Board of Urology. Member of Societe Internationale d'Urologie and American Association of Genito-Urinary Surgeons. Past president of the New England Section of American Urological Association and of the American Urological Association. Introduced thoracoabdominal incision in urology and radical retropubic prostatectomy for cancer.

THEODORE E. LOGAN, D.M.D.

Louisville, Ky.



Professor and chairman, department of prosthetic dentistry, University of Louisville School of Dentistry, and chairman of the committee on postgraduate education at the same school. Prosthetic consultant, Ireland Army Hospital, Fort Knox. Past president of the Louisville Dental Society, and currently a delegate from the Kentucky Dental Association to the American Dental Association. Member of the American College of Dentists, American Prosthedontic Society, and a number of honorary and professional societies. Has served on the Curriculum Committee at the University of Louisville School of Dentistry.

H. MARVIN POLLARD, M.D.

Ann Arbor, Mich.



Professor of internal medicine and head of the section of Gastroenterology, University of Michigan Medical School. Received M.D. in 1931 from University of Michigan. Currently chairman, sub-specialty Board of Gastroenterology. Former governor for Michigan of the American College of Physicians, currently regent of ACP, and former president of the American Gastroenterological Association. Member, Central Society for Clinical Research, American Endoscopic Society, American Federation for Clinical Research, AMA, American Association for Cancer Research, and American Association for the study of Liver Diseases.

PRESIDENT'S LUNCHEON

Terrace Room, Kentucky Hotel
11:50

Delmas M. Clardy, M.D., Hopkinsville, Presiding

Invocation
Dr. W. Peyton Thurman, Dean of Students, The Southern Baptist Theological Seminary

Recognition
Delmas M. Clardy, M.D.

Awards Presentation
William H. Bizot, M.D., Louisville, Chairman, KMA Awards Committee

"The American Dilemma"
Philip M. Crane, Ph.D., Peoria, Ill.

WEDNESDAY AFTERNOON SESSION

Harold B. Barton, M.D., Corbin,
Vice-President (Eastern) Presiding

2:00 **"Arteriosclerotic Heart Disease"—Telephone Party Line Conference**

(Sponsored by Smith Kline & French)

Walter S. Coe, M.D., Louisville, Ky., Moderator
Frank C. Spencer, M.D., Lexington, Ky., Co-Moderator
Telephonic participants:
George E. Burch, M.D., New Orleans, La.
William Dock, M.D., Brooklyn, N.Y.
Richard S. Ross, M.D., Baltimore, Md.

3:00 **Visit Exhibits**

3:30 **"Treatment of Acne Vulgaris"**
Arthur C. Curtis, M.D., Ann Arbor, Mich.

3:50 **"Who is an Alcoholic?"**
Jackson A. Smith ,M.D., Chicago, Ill.

4:10 **"Combined Irradiation and Surgery for Cancer of the Head and Neck"**
Joseph H. Ogura, M.D., St. Louis, Mo.

THURSDAY, SEPTEMBER 23

MORNING SESSION

General Session

Kenneth M. Eblen, M.D., Henderson
Vice-President (Western) Presiding

9:00 **"Epidemiologic Approaches to the Assessment of Causal Factors in Chronic Respiratory Disease"**
Leonard M. Schuman, M.D., Minneapolis, Minn.

9:20 **"Late Complications of Gastric Surgery for Peptic Ulcer"**
H. Marvin Pollard, M.D., Ann Arbor, Mich.

9:40 **"Surgical Considerations in Hypertension"**
H. William Scott, Jr., M.D., Nashville, Tenn.

10:00 **Visit Exhibits**

ARTHUR C. CURTIS, M.D.

Ann Arbor, Mich.



Professor and chairman of the department of dermatology at the University of Michigan School of Medicine, former assistant dean and secretary of same school. Former president of the American Board of Dermatology, Detroit Dermatological Society, Society for Investigative Dermatology, American Academy of Dermatology and Syphilology, Central Society for Clinical Research (Detroit), Association of Professors of Dermatology, American Venereal Disease Association, and the AMA Section on Dermatology. Associate editor of Journal of Investigative Dermatology. Fellow, American College of Physicians, and many others.

JACKSON A. SMITH, M.D.

Chicago, Ill.



Professor and chairman, department of psychiatry and neurology, Stritch School of Medicine, Loyola University. M.D., 1943, University of Oklahoma School of Medicine. Former assistant professor of psychiatry, Baylor Medical School. Former director of research, Nebraska State Mental Health Program, and professor of psychiatry and neurology, University of Nebraska College of Medicine. Former clinical director, Illinois State Psychiatric Institute, and former clinical associate professor of psychiatry, University of Chicago. Chairman, American Psychiatric Association Publications Review Committee. Fellow, ACP and APA.

JOSEPH H. OGURA, M.D.

St. Louis, Mo.



Professor of otolaryngology at Washington University School of Medicine. President, American Society for Head and Neck Surgery. Fellow, American College of Surgeons. Member, American Academy of Ophthalmology and Otolaryngology, American Society for Ophthalmologic and Otolaryngologic Allergy, American Academy of Facial Plastic and Reconstructive Surgery, Inc., American College of Chest Physicians, and many others. National Institutes of Health consultant, Communicative Disorder Research Training Committee. 1941 graduate of University of California Medical School.

10:30 **Panel Discussion: "Peptic Ulcer"**
Edmund D. Pellegrino, M.D. Lexington, Ky., Moderator
Owings W. Kincaid, M.D., Rochester, Minn.
H. Marvin Pollard, M.D., Ann Arbor, Mich.
H. William Scott, Jr., M.D., Nashville,
Stewart Wolf, M.D., Oklahoma City, Okla.

Lunch — 12:00 Noon

THURSDAY MORNING SESSION

Specialty Group Meeting

Kentucky Eye, Ear, Nose and Throat Society

Room 205 — Convention Center

9:00 **"Frequency of Abnormal AC/A in Comitant Esotropia"**
Charles T. Moran, M.D., Louisville, Ky.

9:45 **"Conservation Surgery for Laryngeal and Pharyngeal Malignancies"**
Joseph H. Ogura, M.D., St. Louis, Mo.

10:15 **Visit Exhibits**

10:45 **Business Meeting — Election of Officers**

11:15 **"Differential Diagnosis and Selection of Cases for Retinal Detachment Surgery"**
Fred M. Wilson, M.D., Indianapolis, Ind.

THURSDAY, SEPTEMBER 23

AFTERNOON SESSION

Specialty Group Meetings

(There will be no General Scientific Session on Thursday Afternoon. Eight Specialty Groups will meet at that time. All KMA members are cordially invited to attend any of these meetings.)

Kentucky Dermatological Society

Louisville General Hospital

2-4:00 **Case Demonstrations and Discussion**

4:00 **Short Business Meeting to Ratify the Constitution and By Laws and for Election of Officers**

Kentucky Eye, Ear, Nose & Throat Society

Room 205 — Convention Center

1:30 **"Diagnostic Tips in External Eye Diseases"**
Roderick Macdonald, Jr., M.D., Louisville, Ky.

2:15 **"Non-Organic Hearing Problems"**
Arthur L. Juers, M.D., Louisville, Ky.

3:00 **Visit Exhibits**

LEONARD M. SCHUMAN, M.D.

Minneapolis, Minn.



Professor of epidemiology, School of Public Health, University of Minnesota School of Medicine; former deputy director in charge of the Division of Preventive Medicine, and former chief, Division of Veneral Disease Control, Illinois Department of Public Health. Diplomate, American Board of Preventive Medicine. Graduate of Western Reserve University School of Medicine, 1940. Former member, Surgeon General's Advisory Committee on Smoking and Health. American Association of Public Health Physicians, American Association of University Professors, Royal Society of Health, and others.

OWINGS W. KINCAID, M.D.

Rochester, Minn.

Co-director, Cardiovascular Laboratory, Mayo Clinic, and assistant professor of radiology at the Mayo Graduate School of Medicine at the University of Minnesota. M.D., University of Louisville, 1946; M. S., University of Minnesota, 1956. Member, American College of Radiology, American Roentgen Ray Society, Radiological Society of North America, and the Minnesota Radiological Society. Consultant in cardiovascular diseases, Alaska Native Health Service and Alaska Heart Association, 1964. Honorary member, Texas and Rocky Mountain Radiological societies.



H. WILLIAM SCOTT, M.D.

Nashville, Tenn.



Professor and chairman of the department of surgery at Vanderbilt University School of Medicine and surgeon-in-chief at the University Hospital. Former associate professor of surgery at Johns Hopkins University School of Medicine. Past president, Society of University Surgeons; former vice-chairman, American Board of Surgery. M.D., Harvard, 1941. Member of American Association for Thoracic Surgery, ACS, American Gastroenterological Association, American Heart Association, American Surgical Association, the Halsted Society, Pan-Pacific Surgical Association, International Cardiovascular Society, International Society of Surgery, and others.

3:30 "The After-care and Follow-up of Retinal Detachment Patients"
Fred M. Wilson, M.D., Indianapolis, Ind.

4:30 "Better Safe than Sorry — an 'I' Must"
Edward C. Shrader, M.D., Louisville, Ky.

Kentucky Chapter, American Academy of General Practice

Assembly Hall — Convention Center

2:00 "Are You a Psychiatrist?"
Jackson A. Smith, M.D., Chicago, Ill.

2:30 "You're an Orthopedist?"
Eugene Q. Parr, M.D., Lexington, Ky.

3:00 Visit Exhibits

3:30 "So You're a Dermatologist?"
S. Randolph Scheen, M.D., Louisville, Ky.

4:00 "Did You Know You're an Ophthalmologist?"
Roderick Macdonald, Jr., M.D., Louisville, Ky.

Kentucky Chapter, American College of Physicians

Room 101 — Convention Center

2:00 "Treatment of Delirium Tremens"
Colonel Robert J. Hoagland, M.C., Fort Knox, Ky.

2:20 "Interesting Roentgen Manifestations of Lung Cancer"
Kenneth C. Tufts, M.D., Lexington, Ky.

2:40 "Brachial Angiography in Rheumatoid Arthritis and Related Disorders"
David H. Neustadt, M.D., Louisville, Ky.

3:00 Visit Exhibits

3:30 "Recent Developments in Our Knowledge of Small Bowel Absorption"
H. Marvin Pollard, M.D., Ann Arbor, Mich.

4:10 Functional Hypoglycemia and Duodenal Ulcer Disease"
A. Evan Overstreet, M.D., Louisville, Ky.

Kentucky Psychiatric Association

Room 204 — Convention Center

2:00 "The Relation of Social and Psychological Factors to Myocardial Infarction"
Stewart Wolf, M.D., Oklahoma City, Okla.

3:00 Visit Exhibits

3:30 "Long Term Study of a Case of Multiple Personality"
Glenn M. Weaver, M.D., Cincinnati, O.

Kentucky Association of Public Health Physicians

Room 206 — Convention Center

2:00 "The Epidemiology of Chronic Disease and Its Public Health Applications"
Leonard M. Schuman, M.D., Minneapolis, Minn.

3:00 Visit Exhibits

FRED M. WILSON, M.D.
Indianapolis, Ind.



Professor and chairman of the department of ophthalmology at the Indiana University Medical Center and director of the ophthalmology laboratory. Former Instructor at the Uuniversity of Illinois College of Medicine, and a member of the staff of the Illinois Eye and Ear Infirmary. Consultant in ophthalmology at the Veterans Administration Hospital in Indianapolis. Member of the Indiana Advisory Committee for the Blind and the Indiana Special Education Committee for the Visually Handicapped. Member National Society for the Prevention of Blindness, American Board of Ophthalmology.

STEWART G. WOLF, M.D.
Oklahoma City, Okla.



Currently professor and head of the department of medicine at the University of Oklahoma School of Medicine, consultant in internal medicine at Will Rogers Veterans Administration Hospital, consultant professor of psychiatry, neurology and behavorial sciences, U. of Okla., and other positions. Graduated in 1938 from Johns Hopkins University School of Medicine. Former faculty member of Cornell University Medical College, former clinical associate neuropsychiatrist at Bellevue Hospital and associate attending physician at New York Hospital. Past president of American Federation for Clinical Research and American Psychosomatic Society.

Kentucky Chapter, American College of Radiology

Room 203 — Convention Center

2:00 "Obstructive Malformations of the Right Ventricle and Pulmonary Arteries"
Owings W. Kincaid, M.D., Rochester, Minn.

3:00 Visit Exhibits

3:30 "Angiography in Renal Vascular Disease"
Owings W. Kincaid, M.D., Rochester, Minn.

Kentucky Chapter, American College of Surgeons

Room 104 — Convention Center

2:00 "Surgical Management of Cushing's Syndrome"
H. William Scott, Jr., M.D., Nashville, Tenn.

2:30 "Shock and Massive Liver Injury"
M. Atik, M.D., Louisville, Ky.

2:50 "Advances in Cardiac Surgery"
Allan M. Lansing, M.D., Louisville, Ky.

3:10 Visit Exhibits

3:40 "Burn Stress; Pseudo Diabetes"
Giles M. Stephens, M.D., Louisville, Ky.

4:00 "Urinary Tract Trauma"
Robert Lich, M.D., Louisville, Ky.
Lonnie W. Howerton, M.D., Louisville, Ky.

New Member Orientation Course Set by KMA for Sept. 20

Over 100 new KMA members will have an opportunity to take the first KMA Orientation Course which will be held at the Kentucky Hotel Monday, September 20 during the Association's 1965 Annual Meeting.

The program was approved in principle by the KMA House of Delegates in 1963 and reaffirmed at the 1964 session of the House.

Many hours of preparation by the Orientation Committee promise an outstanding program designed to better equip the new KMA member in meeting present-day responsibilities as a citizen and a physician. The fast-moving session will begin promptly at 8:30 a.m. and will adjourn following the luncheon program.

Letters of invitation have been sent to those members who have joined the Association during this calendar year, and the members of the Orientation Committee have announced that any KMA member is welcome to attend. Following is the program to be presented at the First Orientation Course beginning on Monday, September 20.

KMA Orientation Course Kentucky Hotel

September 20, 1965

Moderator

N. Lewis Bosworth, M.D., Lexington, Chairman

8:00 a.m. Registration

8:30 a.m. Welcome and Introduction
Delmas M. Clardy, M.D., Hopkinsville, KMA President

8:35 a.m. Structure — Function — Policies of Organized Medicine
Andrew M. Moore, M.D., Lexington, Past President, Fayette County Medical Society
Kentucky Medical Association
Henry B. Asman, M.D., Louisville, KMA Secretary
American Medical Association
Robert C. Long, M.D., Louisville, Member AMA Board of Trustees

9:20 a.m. "Community Relations"
To be Announced

9:40 a.m. "Health Insurance" (Blue Cross-Blue Shield)
J. Ed McConnell, Louisville, Vice-President, Blue Cross-Blue Shield

9:55 a.m. "Health Insurance" (Commercial)
To Be Announced

10:10 a.m. Coffee Break

10:25 a.m. "Medical Ethics"
Clyde C. Sparks, M.D., Ashland, KMA Past President

10:45 a.m. "Medico-Legal Aspects"
E. Gaines Davis, Jr., Frankfort, KMA Legal Counsel

11:05 a.m. "Medico-Press Relations"
William Gladden, Louisville, Director of Public Relations, WAVE, Inc.

11:20 a.m. "The National Scene for Medical Legislation"
John C. Quertermous, M.D., Murray, Chairman for National Affairs, KMA Council on Legislative Activities

11:35 a.m. "State Legislation and the KMA Key Man System"
J. C. Cantrill, M.D., Georgetown, Chairman for State Affairs, KMA Council on Legislative Activities

11:45 a.m. "The Physicians Role in Legislation and Politics"
Hoyt D. Gardner, M.D., Louisville, President-Elect, Jefferson County Medical Society

12:15 p.m. Luncheon (with wives)
"What You Can Do"
Mrs. J. Jack Martin, Tompkinsville, President, Woman's Auxiliary to KMA

KEMPAC Seminar and Dinner Set Sept. 20 During KMA Meeting

Two prominent U.S. Senators, one a Democrat, the other a Republican, will be featured at the third annual seminar of the Kentucky Educational Medical Political Action Committee (KEMPAC) to be held Monday evening, September 20 in the Kentucky Hotel during the KMA Annual Meeting.



Senator Dominick

The seminar will get under way with a reception in the Flag Room at 6:00 p.m., followed by a dinner at 7 o'clock, according to Richard F. Greathouse, M.D., Louisville, secretary of the KEMPAC Board of Directors.

One of the Democratic leaders in the Senate, who was tentatively committed to appear on the program, found that it was not possible to be present. The committee will announce the name of the Democratic participant in the September *Journal*, Doctor Greathouse said.

The popular junior senator from Colorado, Peter H. Dominick, from Englewood, will represent the Republican party. Senator Dominick, who represented his district in the 87th Congress, defeated the Democratic incumbent senator, John Albert Carroll, in the November, 1962 general election.

Senator Dominick, a graduate of the Yale School of Law in 1940, served several terms in the Colorado legislature before going to Congress, and has been very active in civic affairs.

The complete program for the seminar, which will also feature others prominent in the medical PAC movement, will be announced in the September *Journal*. The purpose of the seminar is to assist in informing physicians on good political action methods.

1885 KMA President Thompson To be Honored at Meeting

The 1965 Kentucky Medical Association Annual Meeting will be officially titled the Pinckney Thompson Memorial Meeting in remembrance of the 1885 president of the Association.



The tradition of honoring a past president of KMA or some distinguished physician each year at the Annual Meeting was started in 1935.

KMA Historian Eugene H. Conner, M.D., Louisville, has written an interesting biography of Doctor Thompson for the program booklet, which will be distributed at the Annual Meeting in Louisville September 21, 22, and 23.

Your Annual Meeting Phone No. Is 584-2201 for Emergencies

A telephone call to **584-2201** (Area Code 502) will reach you at the KMA Annual Meeting if you wish to be contacted by home, office, or hospital while in Louisville.

The message center, located in the center of the Technical Exhibit Hall at Convention Center, will provide efficient and convenient service for transferring your messages.

No paging of individual physicians will be done. This is due to the arrangement of facilities for the meetings.

Only emergency calls will be posted on the blackboards in the entrance lobby of the Convention Center and in the Scientific Assembly Hall. *All messages* will be on file and may be picked up at the message center. You are urged to check there frequently for your calls.

The message center may be used also to locate other physicians whom you may wish to contact after reaching town. Simply call 584-2201 and ask that your message be delivered.

The phone number rof the Kentucky Hotel is 587-1181. If you wish to be reached Monday, September 20 at the first meeting of the House of Delegates, beginning at 9:00 a.m., or Wednesday evening, September 22, starting at 6:30 for the second session of the House, the call should be directed to the Terrace Room.

Delmas M. Clardy, M.D., KMA president, has emphasized the importance of making full use of the message center in order to receive all calls and messages quickly. The booth will be staffed by trained employees of the Bell Telephone Company, sponsor of the message facilities.



THE BELLE OF LOUISVILLE will be the scene again this year for the annual reunion of the University of Louisville Medical School Alumni on Tuesday evening, September 21. All alumni of the Medical School are invited to attend the reunion, which will include a buffet supper and dancing. The Annual Meeting program booklet will carry any additional information available at the time of publication.

Belle of Louisville Cruise Set For U. of L. Medical Alumni

A four-hour moonlight cruise up the Ohio River on the Belle of Louisville will be the highlight of University of Louisville School of Medicine alumni reunions during the 1965 KMA Annual Meeting.

Ten five-year classes will hold reunions this year. The class of 1915 is celebrating its 50th anniversary and the class of 1940 its 25th.

The cruise on the sternwheeler is scheduled for Tuesday, September 21. The boat will leave the Fourth Street dock at 6:00 p.m. and return at 10:00 p.m. A delicious buffet supper and dancing to the orchestra of Jeannie Crume is included in the ticket price of $5.00.

Reservations will be limited to 600. You are urged to mail your reservations as early as possible to Les Shively, director of alumni relations at the University.

For additional information on individual reunion parties that may be scheduled for your class, contact your chairman, listed below.

1915 — No chairman.
1920 — No chairman.
1925 — Everett H. Baker, M.D., Louisville.
1930 — Clifford Wilson, M.D., Kansas City, Mo., (Co-chairman Richard R. Slucher, M.D., Louisville.)
1935 — Paul Mapother, M.D., Louisville.
1940 — Edwin P. Scott, M.D., Louisville.
1945 — Robert B. Nolan, M.D., Louisville.
1950 — Hoyt D. Gardner, M.D., Louisville.
1955 — C. Ray Potts, M.D., Louisville.
1960 — David F. Archer, M.D., Louisville.

Telephone Seminar New Feature On KMA Scientific Program

A "first-time" feature of the 1965 KMA Annual Meeting scientific program will be a telephone party line seminar Wednesday afternoon, September 22, at 2:00 p.m. in the Convention Center.

"Arteriosclerotic Heart Disease" will be the subject of this hour-long session moderated by Walter S. Coe, M.D., Louisville, and Frank C. Spencer, M.D., of the department of surgery at the University of Kentucky College of Medicine.

Other participants include such outstanding nationally-recognized speakers as George E. Burch, M.D., professor and chairman of the department of medicine, Tulane, William Dock, M.D., professor of medicine at the State University of New York's Downstate Medical Center; and Richard S. Ross, M.D., professor of medicine at Johns Hopkins. All three will speak by telephone connection from their respective cities.

The party line seminar (Tele-Lecture) is being sponsored by the Smith Kline & French Laboratories and is a "first" in their post-graduate support program. KMA President Delmas M. Clardy, M.D., urges your attendance at this outstanding presentation.

House to Elect '65-'66 Officers At September 22 Session

KMA officers for the 1965-66 associational year will be elected at the second session of the KMA House of Delegates on Wednesday evening, September 22. Offices to be filled at that time are:

President-Elect	(Eastern)	One Year
Vice-Presidents	(Central)	One Year
	(Eastern)	One Year
	(Western)	One Year

* Speaker of the House: Three Years. (Incumbent Garnett J. Sweeney, M.D., Liberty)
* Vice-Speaker: Three Years. (Incumbent George F. Brockman, M.D., Greenville)
* Delegates to the AMA: Two Years. (Incumbents Wyatt Norvell, M.D., New Castle, and John C. Quertermous, M.D., Murray)
* Alternate Delegates to the AMA: Two Years. (Incumbents Charles C. Rutledge, M.D., Hazard, and William W. Hall, M.D., Owensboro)

Trustees for five districts will be elected this year. Of the five incumbents, O. Leon Higdon, M.D., and Gabe A. Payne, M.D., have served only one term and are eligible for re-election. Dixie E. Snider, M.D., Thomas O. Meredith, M.D., and William C. Hambley, M.D., have served two full terms and therefore may not succeed themselves. A list of districts to elect trustees follows:

First District (incumbent O. Leon Higdon, M.D., Paducah)
Third District (incumbent Gabe A. Payne, M.D., Hopkinsville)
Fourth District (incumbent Dixie E. Snider, M.D., Springfield)
Twelfth District (incumbent Thomas O. Meredith, M.D., Harrodsburg)
Fourteenth District (incumbent William C. Hambley, M.D., Pikeville)

All are eligible for re-election.

AMA-ERF Workshop to be Feature Of Woman's Auxiliary Meeting

An AMA-Education and Research Foundation Workshop, the first of its kind to be presented at any auxiliary meeting, will be held September 20 as a part of the annual meeting of the Woman's Auxiliary to KMA, which will open the following day at the Kentucky Hotel.

The workshop, sponsored by AMA-ERF Affairs of Chicago, will be conducted by Mrs. A. Y. Wilcox, Jr., St. Petersburg, Fla., Southern Region chairman of AMA-ERF for the Woman's Auxiliary to the AMA. The session will begin at 2:00 p.m. Monday afternoon at the Kentucky.

Designed for county presidents and ERF county chairmen, the workshop is for the benefit of local auxiliaries throughout Kentucky, and all interested WA-KMA members are cordially invited to attend.

Top KMA Awards to Be Presented At President's Luncheon

The three traditional awards of KMA will be presented again this year at the President's Luncheon to be held in the Terrace Room of the Kentucky Hotel at 11:50 a.m. Wednesday, September 22, William H. Bizot, M.D., Louisville, Awards Committee chairman, has announced.

The awards, which are presented annually, are the Distinguished Service Medal, the Outstanding General Practitioner Award, and the R. Haynes Barr Award for a layman active in the field of public health.

Last year the recipients were G. L. Simpson, M.D., Greenville, Distinguished Service; Lloyd M. Hall, M.D., Salyersville, Outstanding General Practitioner; and Mrs. Betty Wilson, Owensboro, R. Haynes Barr Award.

Nominations for recipients of the first two awards will be made by the Awards Committee to the House of Delegates at its first session on Monday morning, September 20, and a final selection will be made by the House at that time. Nominations may be made from the floor. The committee selects the recipient of the Barr award.

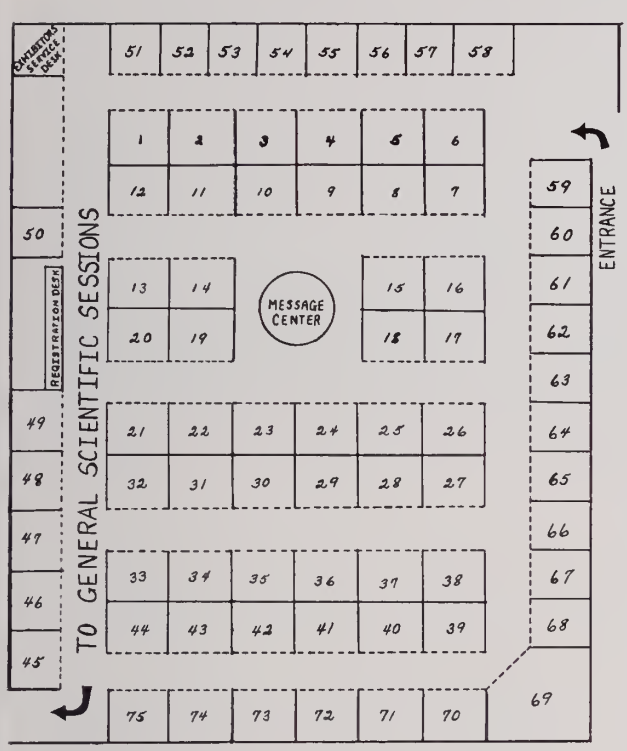
Members of the Awards Committee, in addition to Doctor Bizot, are: Neal Calhoun, M.D., Madisonville; Ollie B. Emerine, M.D., Elizabethtown; William O. Preston, M.D., Lexington; and Richard H. Weddle, M.D., Somerset.

Make Hotel Reservations Now

For those who have not made hotel arrangements for the Annual Meeting of the Kentucky Medical Association in September, KMA President Delmas M. Clardy, M.D., urges that this be done as soon as possible.

Excellent accommodations are available in hotels and motels in the downtown area of Louisville, or within easy access of the facilities to be used for the Annual Meeting. So that you may be sure of rooms, you are reminded to make your reservations now.

Technical Exhibits to be Outstanding, Varied



Seventy-five carefully selected technical exhibits featuring the newest and best in medical products, information and equipment, will be a major attraction again this year at the KMA Annual Meeting.

A 30-minute intermission has been scheduled during each general scientific and specialty group session for your convenience in visiting the exhibits. Literature and demonstrations helpful to you in your daily practice will be made available through informed personnel staffing each booth. You are urged to take this opportunity to examine these excellent exhibits.

TECHNICAL EXHIBITORS

Abbott Laboratories (46)
Ames Company, Inc. (60)
Arnar-Stone Laboratories, Inc. (29)
Audio-Digest Foundation (70)
Ayerst Laboratories (13)
Baker Laboratories, Inc. (47)
Blaine Company (51)
Blue Cross-Blue Shield (25)
Borden Company (52)
Bristol Laboratories (73)
Burroughs Wellcome & Co. (44)
Burton, Parsons & Co. (75)
Carnation Company (66)
Ciba Pharmaceutical Company (20)
Coca-Cola Company (69)
Dictaphone Corporation (40)
Dome Chemicals, Inc. (27)
Eaton Laboratories (50)
Encyclopaedia Britannica, Inc. (67)
Geigy Pharmaceuticals (11)
Gerber Products Company (38)
Great Books of the Western World (34)
Guild of Prescription Opticians of Kentucky (9)
John Hancock Insurance Co. (68)
Hewlett-Packard Company (31)
Johnson & Johnson (59)
Kay Surgical, Inc. (21)
Lederle Laboratories (6)
A. P. Lee (62)
Eli Lilly & Company (15)
J. B. Lippincott Co. (22)
J. A. Majors Company (7)
Malkin Instrument Company (74)
McNeil Laboratories, Inc. (8)
Mead Johnson Laboratories (12)
Medco (64)
Medical Protective Company (63)
Merck Sharp & Dohme (16)
William S. Merrell Co. (2)
C.V. Mosby Company (32)
Mutual Benefit Life Insurance Co. (48)
National Drug Co. (58)
Ortho Pharmaceutical Corporation (56)
Parke, Davis & Company (14)
Pfizer Laboratories (43)
William P. Poythress & Co. (54)
Ransdell Surgical, Inc. (72)
R. J. Reynolds Tobacco Co. (36)
A. H. Robins Company, Inc. (57)
Roche Laboratories (19)
William H. Rorer, Inc. (18)
Ross Laboratories (49)
Sandoz Pharmaceuticals (17)
Schering Corporation (23)
Sealy Mattress Co. (4)
G. D. Searle & Company (39)
Sherman Laboratories (55)
Siemens (65)
Smith Kline & French Laboratories (10)
Smith, Miller & Patch (53)
E. R. Squibb & Sons (26)
Stuart Company (41)
Syntex Laboratories, Inc. (37) & (71)
Tafel Surgical Supply Co., Inc. (28)
Thermo-Fax Sales, Inc. (30)
United States Tobacco Co. (3)
U.S. Vitamin & Pharmaceutical Corp. (42)
Upjohn Company (45)
Wallace Laboratories (1)
Warner-Chilcott Laboratories (33)
Warren-Teed Pharmaceuticals, Inc. (35)
Westwood Pharmaceuticals (5)
Max Wocher & Son Company (24)
Zimmer-Warsaw (61)



LOUISVILLE COUNTRY CLUB'S beautiful 18-hole golf course on Upper River Road in Louisville will be the location of this year's KMGA golf tournanment, to be held Monday, September 20. The tournament is held annually in conjunction with the KMA Annual Meeting.

Louisville Country Club to Host 1965 KMA Golf Tournament Sept. 20

The Louisville Country Club on Upper River Road, noted for its beautiful golf course, will be the scene of the 1965 Kentucky Medical Golf Association Tournament September 20.

The tournament, an annual event, is being held again this year in conjunction with the KMA Annual Meeting in Louisville. The Country Club will be open that day only to KMA members entering the tournament, according to James Douglas, M.D., Louisville, chairman of the KMA Golf Committee.

All participants will tee off between 10:00 a.m. and 1:00 p.m. KMA members desiring to play in this year's tournament must submit their dues and application forms prior to the registration deadline of Wednesday, September 1. *(See Application Form Below.)*

Locker room attendants, pro-shop attendants, and caddies will be made available by the Club. A limited number of golf carts will be available.

Permanent trophies will be given to low net and low gross winners in the championship and senior divisions. Other prizes will be presented. The Bankers Handicap System will be used. Participants need not submit handicaps.

APPLICATION FOR MEMBERSHIP

KMA Golf Association

Please complete and return immediately to: KMA Golf Committee
Kentucky Medical Association
3532 Janet Avenue, Louisville, Kentucky 40205

Name

Address (Town)

Amount enclosed: $7 (Regular playing member) $4 (non-playing member)

....$4 (I am a member of) Others I would like to play with are:

..... I would like to tee off at the following time

TOURNAMENT WILL BE HELD MONDAY, SEPTEMBER 20.

PROGRAM

FORTY-THIRD ANNUAL CONVENTION

Of The

WOMAN'S AUXILIARY

To The

KENTUCKY MEDICAL ASSOCIATION

SEPTEMBER 21 - 22 - 23

1965

KENTUCKY HOTEL **LOUISVILLE, KENTUCKY**

REGISTRATION

Lobby, Kentucky Hotel

Monday	12 Noon - 5:00 PM
Tuesday	7:30 AM - 5:00 PM
Wednesday	9:00 AM - 11:00 AM

(All times are Eastern Standard)

PRE-CONVENTION AMA-ERF WORKSHOP—

MONDAY, SEPTEMBER 20—1 PM

Mrs. A. Y. Wilcox, Jr., Florida, National Southern Regional Chairman, AMA-ERF, Conductor.

TUESDAY, SEPTEMBER 21

8:00 AM

Pre-convention Board Breakfast (subscription): Parlor B, Kentucky Hotel. All general officers, chairmen of standing and special committees, three immediate past presidents, councilors, co-ordinator for members-at-large, and the county auxiliary presidents are urged to attend.

10:00 AM

MIRROR ROOM

Formal opening of the 43rd Annual Convention of the Woman's Auxiliary to the Kentucky Medical Association.

Mrs. J. Jack Martin, President, presiding

Invocation Mrs. C. E. Crabtree, Louisville, Chaplain

Pledge of Allegiance to the Flag
Mrs. Robert B. Breeding, Monticello

Pledge of Loyalty Mrs. Earl W. Roles, Louisville, National Chairman, Committee on By-laws

Address of Welcome Mrs. Harold B. Graves, Louisville

Presentation of Distinguished Guests
Mrs. J. Jack Martin, Tompkinsville

In Memoriam Mrs. C. E. Crabtree, Louisville. Chaplain

Candlelighters:
Mrs. Julian Hardaway, Danville
Mrs. Bernard Schoo, Louisville
Mrs. Ben W. Crawford, Lexington
Mrs. Lloyd M. Hall, Salyersville

Violin Solo . . "Elegie" by J. Massenet
Mrs. Clyde Sparks, Ashland

Vocal Solo . . "Praise Be To Thee" by G. F. Handel
Mrs. Douglas M. Haynes, Louisville

Piano Accompanist for Mrs. Sparks and Mrs. Haynes
Mrs. Walter L. Wilson, Lyndon

Poem . . "Builder of Mountains" . Mrs. C. E. Crabtree

Adoption of Convention Rules
Mrs. C. Melvin Bernhard, Louisville
Parliamentarian

Announcements ... Mrs. Raymond E. Jones, Louisville
Convention Chairman

Roll Call of Delegates . Mrs. James A. Harris, Paducah
Recording Secretary

Minutes of the 42nd Annual Convention
Mrs. James A. Harris

Report of the 1965 National Convention
Mrs. Lester R. Bryant, Lexington

Report of the Councilor of the Woman's Auxiliary to the Southern Medical Association
Mrs. Raymond Dodson Sanders, Williamsburg

Greetings Mrs. John Freer, Lexington
President, WA-SAMA-Lexington

Greetings Mrs. Theodore Buckner, Louisville
President, WA-SAMA-Louisville

President's Address Mrs. J. Jack Martin

Reports of Officers

President-Elect and Membership Chairman
Mrs. Robert J. Salisbury, Mt. Sterling

Vice-Presidents . . Mrs. Ballard W. Cassady, Pikeville
Mrs. Charles C. Kissinger, Henderson
Mrs. O. L. May, Danville
Mrs. Robert A. Stewart, Ashland

Treasurer Mrs. William C. Durham, Louisville

Corresponding Secretary Mrs. Lewis Dickinson, Glasgow

Reports of Councilors

Reports of Chairmen

Old Business

New Business

Resolution from the Board of Directors

Report of Nominating Committee
Mrs. J. Murray Kinsman, Chairman

Presentation of the 1965-66 Budget
Mrs. David M. Cox, Louisville
Finance Chairman

Election of the 1965-66 Nominating Committee

KEMPAC Presentation Hoyt D. Gardner, M.D., Louisville, AMPAC Board of Directors
Report of Registration Mrs. Morgan R. Colbert, Louisville

LUNCHEON

12:30 PM

PARLORS B AND C

Honoring

Past Presidents, Members-at-Large, and Distinguished Guests

Invocation Mrs. Paul E. Lett, Lancaster
Chairman, International Health Activities
Presentation of Membership Awards
Mrs. Robert J. Salisbury
"Focus on Haiti" Dr. and Mrs. Charles F. Wilson, Pikeville
Introduction by Mrs. George P. Archer, Prestonsburg, Chairman, Program Committee

2:00 PM

MIRROR ROOM

Address Everett H. Baker, M.D., Louisville
President-Elect, KMA
Reports of County Auxiliary Presidents
Vice-Presidents presiding: Mrs. Ballard W. Cassady
Mrs. Charles C. Kissinger
Mrs. O. L. May
Mrs. Robert A. Stewart

Barren-Metcalfe, Bell, Bourbon, Boyd-Carter-Greenup, Boyle, Calloway, Daviess, Fayette, Franklin, Fulton, Hardin-LaRue, Harlan, Henderson, Hopkins, Jefferson, Johnson-Floyd-Magoffin, Laurel, Madison, Marion-Washington, Mason, McCracken, Montgomery-Bath-Menifee, Muhlenberg, Perry-Knott, Pike, Pulaski, Rowan, Taylor-Green, Warren, Whitley.

WEDNESDAY, SEPTEMBER 22

9:15 AM

MIRROR ROOM

Invocation Mrs. Eli George, Lebanon
Roll Call Mrs. James A. Harris
Reading of Minutes Mrs. James A. Harris
Presentation of Distinguished Guests
Announcements Mrs. Raymond E. Jones
Address Delmas M. Clardy, M.D., Hopkinsville
President, KMA
Presentation of the Community Service Award
Mrs. J. Jack Martin, President
Address ... Mrs. Asher Yaguda, Newark, New Jersey
President-Elect, Woman's Auxiliary to AMA
Election of Officers
Installation of Officers Mrs. Asher Yaguda
Presentation of Gavel and Pin Mrs. J. Jack Martin
Inaugural Address Mrs. Robert J. Salisbury
Announcement of Committee Chairmen
Mrs. Robert J. Salisbury
Final Report of Registration ...Mrs. Morgan R. Colbert
Courtesy Resolutions
Mrs. J. Murray Kinsman, Louisville

LUNCHEON AND FASHION SHOW

12:30 PM

FLAG ROOM

Honoring

Mrs. Asher Yaguda, President-Elect
Woman's Auxiliary to the American Medical Association

Invocation Mrs. Eugene Castle, Madisonville
Presentation of Distinguished Guests
Presentation of Officers
Fashion Show
Adjournment

THURSDAY, SEPTEMBER 23

8:45 AM

PARLOR A

Post-convention Board Breakfast

Presiding Mrs. Robert J. Salisbury
Invocation Mrs. A. S. Holmes, Corbin
Membership Committee Meeting

RULES OF THE CONVENTION

1. Badges must be worn by the voting body during all general sessions.
2. Delegates' privileges are transferable only with the knowledge and approval of the Credentials Committee.
3. Officers and delegates are requested to sit in the sections assigned to them. All persons appearing on the program are requested to sit near the front.
4. When addressing the Chair, a speaker shall announce her name and the name of her county auxiliary.
5. Each speaker from the floor shall be limited to *two* minutes. No one shall speak more than twice on the same question.
6. Officers giving reports shall be limited to *five* minutes.
7. County presidents giving reports shall be limited to *two* minutes unless more time is specified by the president.
8. A time keeper shall notify each speaker when the allotted time has expired.
9. Only a voting member shall offer motions and vote. Motions must be in writing, signed by the mover, and presented to the recording secretary, when so requested by the Chair.
10. No announcements shall be made from the floor. All announcements of a vital nature shall be made from the platform with the consent of the president after they have been submitted in writing to her.
11. The right to the floor may be granted to non-delegate members by consent of the Chair or by majority vote of the delegates.
12. Visitors are welcome to all the general sessions. All visitors and auxiliary members are requested to register.

Pledge of Loyalty

I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals.

1965 State Convention Committees

General Chairman Mrs. Raymond E. Jones, Louisville
Co-Chairman Mrs. Hugh P. Adkins, Louisville
Registration Mrs. Morgan R. Colbert, Louisville
Decorations Mrs. William J. Hockaday, Louisville
Mrs. Elbert G. Christian, Louisville
Mrs. Walter Fox, Louisville
Finance Mrs. William C. Durham, Louisville
Publicity Mrs. Rudy J. Ellis, Louisville
Exhibits Mrs. Frederick C. Ehrman, Louisville
Fashion Show Mrs. S. Randolph Scheen, Louisville
Tickets Mrs. William F. Hawn, Louisville
Hobby Show Mrs. Robert B. Nolan, Louisville
Mrs. Edward Fadell, Louisville
Mrs. Robert Lykins, Louisville
Hospitality
Mrs. Michael S. Zeman, Louisville
Mrs. Joseph L. Goldstein, Louisville
Mrs. William J. Schutz, Louisville
County Auxiliary Gift Drawing .. Mrs. Bernard Asman, Louisville
Official Hostesses ...Mrs. Arthur R. Kasey, Louisville
Mrs. Charles F. Blankenship, Louisville
Mrs. W. Proctor Eubank, Louisville
Mrs. Carlisle Morse, Louisville
Tellers Mrs. W. F. Clarke, Pikeville
Mrs. David Orrahood, Owensboro
Mrs. Carlos Hernandez, Elizabethtown
Pages Mrs. David B. Stevens, Lexington
Mrs. James L. Ferrell, Paris
Mrs. Keith Coverdale, Bowling Green
Time Keepers Mrs. Edward S. Wilson, Pineville
Mrs. William R. Bushong, Tompkinsville

STATE OFFICERS

President Mrs. J. Jack Martin, Tompkinsville
President-Elect . Mrs. Robert J. Salisbury, Mt. Sterling
First Vice-President Mrs. Ballard W. Cassady, Pikeville
Second Vice-President Mrs. Charles C. Kissinger, Henderson
Third Vice-President Mrs. O. L. May, Danville
Fourth Vice-President Mrs. Robert A. Stewart, Ashland
Recording Secretary ... Mrs. James A. Harris, Paducah
Treasurer Mrs. William C. Durham, Louisville
Corresponding Secretary Mrs. Lewis Dickinson, Glasgow
Parliamentarian .. Mrs. C. Melvin Bernhard, Louisville

ADVISORY COMMITTEE

J. Andrew Bowen, M.D., Louisville
Jesse T. Funk, M.D., Bowling Green
Coleman C. Johnston, M.D., Lexington

IMMEDATE PAST PRESIDENTS

Mrs. Guy Morford, Owensboro
Mrs. James Sears Rich, Lexington
Mrs. J. Murray Kinsman, Louisville

DISTRICT COUNCILORS

1st—Mrs. Walker M. Turner, Paducah
2nd—Mrs. John A. Logan, Sebree
3rd—Mrs. G. L. Simpson, Sr., Greenville
4th—Mrs. Wanless R. Mann, Campbellsville
5th—Mrs. Carlisle Morse, Louisville
6th—Mrs. Daryl P. Harvey, Glasgow
7th—Mrs. Carl Cooper, Jr., Bedford
8th—Mrs. Morris M. Garrett, Ft. Thomas
9th—Mrs. J. E. McKinney, Maysville
10th—Mrs. James Sanky Williams, Nicholasville
11th—Mrs. W. C. Cloyd, Richmond
12th—Mrs. Morris Holtzclaw, Somerset
13th—Mrs. John S. Ashworth, Ashland
14th—Mrs. Lloyd M. Hall, Salyersville
15th—Mrs. Samuel M. Adams, London
Co-Ordinator for Members-at-Large—Mrs. Richard E. Davis, South Carrollton

COMMITTEE CHAIRMEN

American Medical Association—Education & Research Foundation Mrs. Robert C. Long, Louisville
Benevolence Mrs. Jesse T. Funk, Bowling Green
Blue Grass News, Editor Mrs. U. Ray Ulferts, Louisville
Co-Editor Mrs. Earl W. Roles, Louisville
Co-Editor Mrs. Victor P. Dalo, Louisville
By-Laws Mrs. C. Melvin Bernhard, Louisville
Chaplain Mrs. C. E. Crabtree, Louisville
Community Service Mrs. Frank T. Smith, Middlesboro
Convention Mrs. Raymond E. Jones, Louisville
Co-Chairman Mrs. Hugh P. Adkins, Louisville
Disaster Preparedness Mrs. J. Andrew Bowen, Louisville
Doctor's Shop Mrs. Bacon R. Moore, III, Harrodsburg
Finance Mrs. David M. Cox, Louisville
Health Careers Mrs. Hoyt D. Gardner, Louisville
Co-Chairman Mrs. A. S. Holmes, Corbin
Historian Mrs. Paul M. Taylor, Providence
International Health Activities Mrs. Paul E Lett, Lancaster
Legislation Mrs. J. T. Linville, Louisville
Co-Chairman ...Mrs. Peter Bosomworth, Lexington
McDowell House Mrs. Walker Owens, Danville
Membership ... Mrs. Robert J. Salisbury, Mt. Sterling
Mental Health Mrs. John Quertermous, Murray
Nominations Mrs. J. Murray Kinsman, Louisville
Past Presidents .. Mrs. J. Murray Kinsman, Louisville
Program Mrs. George P. Archer, Prestonsburg
Publicity Mrs. Rudy J. Ellis, Louisville
Reports Mrs. W. Proctor Eubank, Louisville
Rural Health Mrs. Everett D. Blair, Morehead
Safety Mrs. Donald E. Howard, Frankfort
WA-SAMA — WA-KMA Liaison
Lexington Mrs. William R. Willard, Lexington
Louisville Mrs. C. Douglas LeNeave, Louisville

PAST PRESIDENTS

*1923—Mrs. Graham Lawrence, Shelbyville
*1924—Mrs. Graham Lawrence, Shelbyville
*1925—Mrs. Van Albert Stilley, Benton
*1926—Mrs. Van Albert Stilley, Benton
*1927—Mrs. William M. Martin, Harlan
*1928—Mrs. James Thomas Reddick, Paducah
1929—Mrs. P. E. Blackerby, Louisville
1930—Mrs. E. B. Houston, Murray
*1931—Mrs. George A. Hendon, Louisville
1932—Mrs. Arthur T. McCormack, Louisville
*1933—Mrs. Bartlett K. Menefee, Covington
*1934—Mrs. Joseph L. Greenwell, New Haven
1935—Mrs. Luther Bach, Florence

(Continued on Page 640)

too young to be so tired...





revive interest... restore activity promptly with

Alertonic®

Three tablespoonfuls (45 cc.) contain:

Pipradrol hydrochloride		2 mg.
Vitamin B_1 (thiamine hydrochloride)	(10 MDR*)	10 mg.
Vitamin B_2 (riboflavin)	(4 MDR*)	5 mg.
Vitamin B_6 (pyridoxine hydrochloride)		1 mg.
Nicotinamide	(5 MDR*)	50 mg.
Choline†		100 mg.
Inositol†		100 mg.
Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
Cobalt (as chloride)		1 mg.
Manganese (as sulfate)		1 mg.
Magnesium (as acetate)		1 mg.
Zinc (as acetate)		1 mg.
Molybdenum (as ammonium molybdate)		1 mg.

Alcohol 15%

*Multiple of adult Minimum Daily Requirement supplied
†Requirement in human nutrition not yet established

the need for a tonic knows no age

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SIDE EFFECTS: Blurring of vision, dry mouth, difficult urination or flushing and dryness of the skin may occur at higher dosage levels, rarely at the usual dose.

*This one at Oak Creek, Castle Rock, Arizona

References: 1. Hock, C. W.: Clin. Med. 8:1932, 1961. 2. Marks, L.: Am. J. Gastroenterol. 27:180, 1957. 3. Palmer, W. L., and Kirsner, J. B.: Therapeutics in Internal Medicine, 2nd ed., F. A. Kyser, Ed., Hoeber, New York, 1953, p. 368. 4. Ryan, J. P., Jenkins, H. J. and Robinson, S. M.: J. Pharmaceut. Sciences 53(9):1084, 1964. 5. Vollmer, H.: Arch. Neurol. & Psychiat. 43:1057, 1940. Abst. J.A.M.A. 115:333, 1940. 6. Wharton, G. K., Balfour, D. C., Jr., and Osman, K. I.: Postgrad Med. 21:406, 1957.

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ORGANIZATION SECTION

Rural Scholarship Fund Board Approves Thirteen New Loans

Thirteen first-year medical students have had their applications approved for loans for the 1965-66 school year by the Board of Trustees of the Rural Kentucky Medical Scholarship Fund, according to C. C. Howard, M.D., Glasgow, Board chairman.

The Fund, in approving these loans, now has a record of giving assistance to or having assisted a total of 270 students since the inception of the program in 1946.

Eight of this year's applicants will attend the University of Kentucky; three, the University of Louisville, one, Vanderbilt; and one, Howard University. In addition, 28 renewal applications of upper-classmen were approved. These students represent U. of L., U. of K., Tulane, and Meharry schools of medicine.

Recipients may choose one of two programs. Under the first, the recipient may receive up to $1,300 for which he promises to practice in an area acceptable to the Fund for one year for each year he gets a loan. Interest of 2% is charged.

The second plan enables the student to borrow up to $2,000 a year provided he contracts to practice in a county where there is a critical shortage of physicians. For each year he practices in one of these counties, one loan will be cancelled.

Critical counties this year are Breathitt, Elliott, Jackson, Knott, Leslie, Magoffin, Martin, Owsley, Powell and Wolfe.

Dr. Hudson Named AMA Pres-Elect; Dr. Appel is New President

Charles L. Hudson, M.D., Shaker Heights, Ohio, was chosen by the American Medical Association as its president-elect during the June Annual Convention in New York. Doctor Hudson had been a member of the AMA Board of Trustees since 1961.

James Z. Appel, M.D., surgeon and general practitioner from Lancaster, Pa., was installed as 1965-66 president during the opening session of the House of Delegates on Sunday, June 20.

Doctor Hudson, a former president of the Ohio State Medical Association, has served the AMA in many significant positions, among them the chairmanship of a number of councils, commissions and committees.

He is vice-president of the American Medical Association Education and Research Foundation Board of Trustees, and recently served as a delegate to the World Medical Association, representing the U.S. chapter of that group. An internist, Doctor Hudson received his medical education at the University of Michigan.



Doctor Hudson



Doctor Appel

The new president, a past vice-chairman of the AMA Board of Trustees, succeeded Donovan F. Ward, M.D., Dubuque, Ia., in office. Doctor Appel was also a member of the AMA Board prior to being chosen president-elect at the AMA Clinical Convention in Miami last November.

Ky. Physicians Represented At AMA Annual Meeting

Wyatt Norvell, M.D., senior delegate from New Castle, led the Kentucky delegation, including delegates J. Thomas Giannini, M.D., Louisville, and John C. Quertermous, M.D., Murray, at the 114th annual meeting of the American Medical Association in June at New York.

Delmas M. Clardy, M.D., KMA president, and Mrs. J. Jack Martin, Tompkinsville, KMA Auxiliary president, attended their respective meetings during the convention.

Kentucky's three alternate delegates, with Deans Donn L. Smith of U. of L. and William R. Willard, U. of K., and a number of other KMA members, attended the sessions of the House of Delegates. Alternates are Charles G. Bryant, M.D., Louisville, William W. Hall, M.D., Owensboro, and Charles C. Rutledge, M.D., Hazard.

The Kentucky delegation caucussed four times during the meeting. Doctor Norvell expressed his gratitude for the cooperation of some ten or twelve Kentucky physicians who covered reference committee meetings and participated in the caucus sessions.

Registration Deadline Sept. 4

September 4 is the last day to register to vote in Kentucky in the November elections, according to John C. Quertermous, M.D., Murray, chairman for national affairs of the KMA Council on Legislative Activities.

"It is vital that every physician in Kentucky cast his vote for the candidate of his choice in this important election", Doctor Quertermous said. If your registration has lapsed or is not properly recorded, be sure to correct this before September 4.

AMA House Re-elects Dr. Willard To Medical Education Council

William R. Willard, M.D., vice-president for the Medical Center at the University of Kentucky, was re-elected to a five year term on the Council on Medical Education by the House of Delegates of the AMA in New York City in June.



Doctor Willard

Doctor Willard was first elected to the Council in 1960 in Miami. The Council on Medical Education is one of three whose members are elected by the House of Delegates.

Doctor Willard is also a member of the Kentucky Rural Scholarship Loan Fund Board of Trustees and the KMA Council on Medical Education and Hospitals.

KAGP Bluegrass Seminar Arranged For August 21-22 in Lexington

Fifteen lecturers from various medical fields are scheduled to appear on the program of the Bluegrass Seminar being planned for the Kentucky Academy of General Practice August 21-22 in Lexington, Robert C. Burkhart, M.D., Lexington, Seminar chairman, reported.

Another feature of the meeting, Doctor Burkhart said, will be the golf tournament arranged for Friday, August 20.

The scientific program, to be held at the Imperial House, is acceptable for seven and one half accredited hours by the American Academy of General Practice.

Other sessions are now being planned for later this year by the KAGP. October 7 is the date set for the meeting at Maysville, and an Industrial Medical Seminar will be held in Louisville October 21, co-sponsored by KMA. Information will be carried on these and additional meetings when available.

'Medicine and Religion' is Theme Of Sixth District Meeting

More than 60 physicians and their guests attended the first-of-its-kind meeting on Medicine and Religion held by the KMA Sixth Trustee District in Bowling Green July 13, according to Rex E. Hayes, M.D., trustee for that district.

Arne E. Larson, assistant director of the AMA Department of Medicine and Religion, was the featured speaker on the program. Doctor Hayes stated that response was excellent, and that most physicians brought their ministers as special guests.

Harold Keen, M.D., Bowling Green, a member of the KMA Committee on Medicine and Religion, was in charge of arrangements for the program.

The Sixth Trustee District Medical Society elected officers at the same meeting. They are: Paul J. Parks, M.D., Bowling Green, president, succeeding Carlisle V. Dodson, M.D., Russellville; and O. L. Davis, M.D. Scottsville, vice-president. Doctor Hayes was elected secretary.

The district is one of the most active in KMA, and generally meets quarterly.

Sen. Thruston Morton is Speaker At AMPAC Dinner June 22

Senator Thruston B. Morton from Kentucky was featured guest speaker at the American Medical Political Action Committee banquet held Tuesday evening June 22 in New York City in conjunction with the AMA Annual Convention.



Senator Morton

A large delegation of Kentucky physicians attended the annual affair. Senator Morton, who urged the profession to become politically active, was applauded several times during his speech, and received a standing ovation at its conclusion.

One of the members of the Board of Directors of AMPAC is Hoyt D. Gardner, M.D., Louisville, former chairman of the Board of the Kentucky Educational Medical Political Action Committee.

Dr. Deju to Head Child Health

Jorge Deju, M.D., Frankfort, has been named director of the division of maternal and child health in the State Department of Health, succeeding Helen B. Fraser, M.D., who died July 16.

Doctor Deju, who has been with the health department for two years, received his medical degree from the University of Havana, Cuba, in 1956, and took additional training at Buffalo, N.Y. He was health officer in Grayson, Meade, Breckinridge, and Hancock Counties for one year.



Richard R. Slucher, M.D., Louisville, congratulates Jefferson County Medical Society Executive Secretary Harry A. Lehman, right, following the presentation of a silver serving tray in appreciation of the latter's ten years of service to the Society. At Doctor Slucher's left are Nathan Zimmerman, M.D., Wathen R. Knebelkamp, John Dromo, Alfred "Butch" Beard, and Dean Eagle. The latter four participated in the after-dinner sports panel discussion.

JCMS Honors Lehman With Gifts After Ten Years of Service

Harry A. Lehman, executive secretary of the Jefferson County Medical Society, was presented with a set of golf clubs and bag, a silver serving dish, and a substantial check, all in recognition of his tenth anniversary with the Society, at its June 28 meeting in Louisville.

Richard R. Slucher, M.D., former KMA president and JCMS president, made the initial presentation, a silver serving tray, in the surprise ceremony during the Society's annual sports outing at the Standard Country Club.

George Sehlinger, M.D., immediate past JCMS president, presented Mr. Lehman with golf equipment. Hoyt D. Gardner, M.D., JCMS president-elect, presented a check. The gifts were made possible by voluntary contributions of individual Society members.

Mr. Lehman, who is active in civic and church affairs in the city, took over the JCMS post in 1955. He came to Louisville from Ft. Wayne, Ind., where he had been executive secretary of the Allen County Medical Society.

Following the presentations, a panel of sports notables in various fields, including Peewee Reese, former baseball great and now a sportscaster, was heard. Roy H. Moore, Jr., M.D., Society president, presided, and Nathan Zimmerman, M.D., was program chairman.

Dr. Hayes Heads Mental Hospital

Ray H. Hayes, M.D., recently clinical director of the USPHS Hospital at Lexington, took over August 2 as superintendent of Central State Hospital at Anchorage.

Doctor Hayes, Mental Health Department district psychiatrist in Eastern Kentucky from 1957 to 1961, had been a staff member at the hospital since that time, and clinical director since 1962. He is a clinical assistant professor of psychiatry at the Univeristy of Kentucky. Doctor Hayes graduated from Georgetown University School of Medicine in 1950.
—Organization

Ky. Auxiliary Members Named To AMA Auxiliary Posts

Four Kentucky physicians' wives, three of whom are past presidents and one the current president of the KMA Woman's Auxiliary, were named to various offices by the Woman's Auxiliary to the AMA at its June meeting in New York.

Mrs. J. Jack Martin, Tompkinsville, who is currently president of the WA-KMA, was named national Southern Region chairman of International Health Activities. Mrs. Earl W. Roles, Louisville, was elected national chairman of the Committee on Bylaws of WA-AMA. She recently served as a national regional vice-president of the organization.

Mrs. J. Murray Kinsman, Louisville, was chosen national Southern Region chairman of Community Service. Mrs. James S. Rich, Lexington, was re-appointed as a contributing editor of the *Bulletin* of the WA-AMA, which will soon have its title changed to *MRS. M.D.*

Fayette County Medical Society Has New Executive Secretary

With the growth of the Fayette County Medical Society and the increasing responsibility to its membership, the Society has employed a full time executive secretary, Fayette County president Thomson R. Bryant, M.D., has announced.



Miss Hancock

Miss Liza Hancock, formerly a secretary in the College of Education at the University of Kentucky, accepted the position in April of this year. While working for the University she was secretary to the chairman of the division of curriculum and four other professors.

Miss Hancock is a native of Louisville, and grew up in Frankfort. She attended the Bowling Green College of Commerce, where she received a one-year diploma in 1962.

KY. M.D.s INVITED TO LAW SEMINAR

You have been invited to attend a two-day seminar on "Professional Negligence" by the Kentucky Bar Association's Section on Insurance Compensation and Negligence session to be held September 10 and 11 at the Campbell House in Lexington. Robert E. Pennington, M.D., chairman of the KMA Board of Trustees, will discuss "The Doctor Talks Back." All KMA members are invited.



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Dr. Thompson of Ky. Health Dept. Dies Suddenly in Frankfort

E. M. Thompson, M.D., 60, director of local health services in the Kentucky State Department of Health, died unexpectedly June 20 at his home in Frankfort.

Doctor Thompson, who was immediate past president of the Kentucky Association of Public Health Physicians, was assistant director of local health from 1959 until 1962, when he became director. Prior to that time he had been health officer for Hart, Logan, Butler and Todd counties and the Lexington-Fayette County Health Department, and had served as director of field training in the state health department from 1945 until 1949.

A graduate of Yale University School of Medicine in 1934, Doctor Thompson also held a master's degree in public health from the University of Michigan.

Kentucky Hospitals to Get Help Of Medical Record Librarians

The members of the KMA Hospital Committee have requested publication of the following service arranged by the Kentucky Association of Medical Record Librarians, in the Journal of KMA.

Miss Martha Barclay, the appointed representative of the KAMRL, announced recently that hospitals throughout Kentucky may utilize the services of medical record librarians as consultants and to train a medical record librarian. In addition, a medical record librarian is available to meet with the medical staff of the local hospital and outline adequate medical procedures.

The hospitals requesting help would pay the cost of $35 a day plus expenses, said Miss Barclay.

WA-AMA Pres-Elect, Mrs. Yaguda, To be Guest of KMA Auxiliary

Mrs. Asher Yaguda, Newark, N.J., president-elect of the Woman's Auxiliary to the American Medical Association, will be the guest of the Woman's Auxiliary to KMA at its annual meeting September 21-23 at the Kentucky Hotel in Louisville.

Mrs. Yaguda, who will address the group on Wednesday, September 22, has just completed a one-year term as first vice-president of WA-AMA, and is a former director of the national organization.

She has served as a delegate to the White House Conferences on Children and Youth, and on Aging, and as chairman of the New Jersey Public Medical Care Commission. She is the first and only woman to serve on the Board of Directors of the New Jersey Hospital Service Plan (Blue Cross).

Dr. Helen Fraser Dies

Helen B. Frazer, M.D., director of the division of maternal and child health in the Kentucky State Department of Health, died at a Louisville hospital July 16. She was 48.

Doctor Fraser had served as consultant to the Children's Bureau in Washington and to the World Health Organization. She helped establish prenatal, pediatric and well-child clinics in Kentucky and in 1962 inaugurated a statewide testing program for phenylketonuria. A graduate of Rush Medical College, she had been maternal and child health director for nine years.

County School Health Chairmen To Hold Meeting Sept. 21

A meeting for all County School Health Committee chairmen will be held Tuesday, September 21 at 3:00 p.m., in Room 207 of the Convention Center, according to O. B. Murphy, M.D., Lexington, chairman of the KMA School Health Committee.

The theme of the meeting will be the medical aspects of sports, including athletic injuries, Doctor Murphy said. The responsibility of medical society school health chairmen will be discussed.

A film on the physical fitness program in the Larue County School system will be the highlight of the session. This program has drawn national attention in connection with the emphasis being placed on physical fitness.

Palsy Center Director Named

Walter E. Badenhausen, Jr., M.D., has been named new director of the United Cerebral Palsy Treatment Center in Louisville, it was announced. Doctor Badenhausen, a native of New York, came to Louisville last year as a fellow in surgery at the University of Louisville School of Medicine.

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Kentucky Registration at AMA New York Meeting Totals 136

One hundred and thirty-six Kentucky physicians registered at the American Medical Association's 1965 annual meeting in New York City June 20-24, according to Lloyd W. Prang, director of the Physician Membership Records section of the AMA.

Last year 87 Kentuckians registered at the San Francisco meeting, and 94 attended the Atlantic City meeting in 1963.

Following is a complete list of Kentucky physicians who registered at the New York meeting this year:

William H. Anderson, M.D., Louisville
George P. Archer, M.D., Prestonsburg
M. Atik, M.D., Louisville
William Bakewell, M.D., Lexington
John T. Bate, M.D., Louisville
Barbara Bates, M.D., Lexington
Martin J. Bell, M.D., Fort Knox
Wallas N. Bell, M.D., Sturgis
Leslie W. Blakey, M.D., Lexington
Joseph Book, M.D., Middlesboro
Joyce Brest, M.D., Owensboro
Stuart Brest, M.D., Owensboro
Charles G. Bryant, M.D., Louisville
Lester Bryant, M.D., Lexington
W. H. Bryant, M.D., Glasgow
G. F. Brockman, M.D., Greenville
Ralph L. Cash, M.D., Princeton
H. B. Caudill, M.D., Lawrenceburg
Walter L. Cawood, M.D., Ashland
H. F. Chambers, M.D., Campbellsville
J. Paul Chapin, M.D., Fort Thomas
Arnold B. Combs, M.D., Lexington
Sam Cooke, M.D., Louisville
David M. Cox, M.D., Louisville
M. R. Cronen, M.D., Louisville
Bohdan V. Cymbala, M.D., Henderson
Richard W. Dame, M.D., Louisville
Douglas David, M.D., Louisville
Sidney Davidson, M.D., Lexington
Royce E. Dawson, M.D., Owensboro
S. S. Dhanjal, M.D., Louisville
Carl Essig, M.D., Lexington
Evalyn G. Evans, M.D., Ashland
W. G. Farnsley, M.D., Louisville
Hoyt D. Gardner, M.D., Louisville
R. Gettlefinger, M.D., Louisville
J. Thomas Giannini, M.D., Louisville
George M. Gumbert, M.D., Lexington
D. P. Hall, M.D., Louisville
M. L. Hall, M.D., Campbellsville
William W. Hall, M.D., Owensboro
M. R. Hamberg, M.D., Louisville
R. P. Harbord, M.D., Lexington
James C. Hart, M.D., Murray
John S. Harter, M.D., Louisville
Fred C. Hauck, M.D., Owensboro
P. T. Higgins, M.D., Hopkinsville
John C. Hill, M.D., Louisville
R. J. Hoagland, M.D., Fort Knox
C. E. Hornaday, M.D., Owensboro
Hugh L. Houston, M.D., Murray
Donald G. Hughes, M.D., Murray
Harris Isbell, M.D., Lexington
V. A. Jackson, M.D., Clinton
Charles B. Johnson, M.D., Russell
Hollis Johnson, M.D., Louisville
Maurice Kaufmann, M.D., Lexington
Paul A. Keeney, M.D., Louisville
Auddie C. Kennedy, M.D., Henderson
Lloyd O. Larsen, M.D., Lexington
Robert Lich, Jr., M.D., Louisville
Robert C. Long, M.D., Louisville
Ralph D. Lynn, M.D., Elkton
Dorothy Y. C. Ma, M.D., Louisville
Paul F. Maddox, M.D., Campton
J. R. McMahon, M.D., Lexington
Merle M. Mahr, M.D., Madisonville
T. R. Marshall, M.D., Louisville
Gaston Maya, M.D., Louisville
George C. McClain, M.D., Benton
William J. McNabb, M.D., Louisa
H. B. McWhorter, M.D., Ashland
John W. Miller, M.D., Louisville
J. F. Minnis, Jr., M.D., Louisville
Allison R. Morgan, M.D., Mayfield
Dean H. Morrow, M.D., Lexington
Carlisle Morse, M.D., Louisville
D. E. Murdoch, M.D., Fort Campbell
David R. Nagle, M.D., Lexington
Arthur J. Nash, M.D., Jenkins
Maurice Nataro, M.D., Louisville
Wyatt Norvell, M.D., New Castle
Earl P. Oliver, M.D., Scottsville
H. Oppenheim, M.D., Louisville
E. D. Pellegrino, M.D., Lexington
N. J. Pisacano, M.D., Lexington
Elliott Podoll, M.D., Louisville
William O. Preston, M.D., Lexington
John C. Quertermous, M.D., Murray
Edward H. Ray, M.D., Lexington
Hugh L. Ray, M.D., Ashland
Joseph B. Reed, M.D., Fort Knox
Ben A. Reid, M.D., Louisville
Samuel E. Reynolds, M.D., Morehead
Earl W. Roles, M.D., Louisville
J. C. Rosenberg, M.D., Lexington
Marjorie Rowntree, M.D., Louisville
Richard H. Rucker, M.D., Paducah
Benjamin F. Rush, M.D., Lexington
Edward I. Rustin, M.D., Pikeville
Charles C. Rutledge, M.D., Hazard
Allen M. Sakler, M.D., Louisville
N. A. Saliba, M.D., Louisville
C. B. Severs, M.D., Valley Station
F. K. Sewell, M.D., Mt. Sterling
B. N. Shaffer, M.D., Lexington
Ingeborg Shaffer, M.D., Lexington
S. A. Shaffer, M.D., Ashland
Arnold Silver, M.D., Louisville
Judah L. Skolnick, M.D, Louisville
Donn L. Smith, M.D., Louisville
Kenneth W. Smith, M.D., Middlesboro
Eugene L. Snowden, M.D., Winchester
L. H. South, M.D., Louisville
Frank C. Spencer, M.D., Lexington
Charles B. Stacy, M.D., Pineville
Robert A. Stewart, M.D., Ashland
Harry J. Stone, M.D., Ashland
Lewis R. Sutton, M.D., Elkton
Jesse W. Tapp, M.D., Lexington
Russell E. Teague, M.D., Frankfort
Walter Thompson, M.D., Louisville
William Thorsen, M.D., Louisville
W. M. Townsend, M.D., Falmouth
F. Norman Vickers, M.D., Louisville
Harry E. Voyles, M.D., Louisville
William M. Waller, M.D., Walton
William V. Walsh, M.D., Lexington
Thomas R. Watson, M.D., Louisville
Max E. Wheeler, M.D., Ashland
William R. Willard, M.D., Lexington
John D. Winebrenner, M.D., Louisville
Carroll L. Witten, M.D., Louisville
William C. Wolfe, M.D., Louisville
Michael S. Zeman, M.D., Louisville

In Appreciation

The original cartoon on the envelope in which your Annual Meeting issue arrived this month is a drawing by Max Ervin, M.D., Louisville anesthesiologist, who frequently lends his talents to other medical groups, such as KEMPAC and the Jefferson County Medical Society, for their publications. The editors of The Journal take this opportunity to thank Doctor Ervin for his efforts on behalf of KMA.

Occupational Health Congress Set

The 1965 Congress on Occupational Health, sponsored annually by the American Medical Association's Council on Occupational Health, will be held concurrently with the annual meeting of the Indiana State Medical Association at the Murat Temple in Indianapolis, October 12-14.

ACP Course to be Held at U. K.

The American College of Physicians Postgraduate Course No. 7, entitled "Pathophysiological Basis of Therapeutics" will be held at the University of Kentucky Medical Center November 15-19, according to E. D. Pellegrino, M.D, director of the course.

The theme of the course will be the disturbances in physiology underlying the clinical manifestations of disease in several organ systems, and the way these disturbances are modified by therapeutic measures. N. J. Pisacano, M.D., will serve as associate director. Registration will be limited to 75.

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

Anesthesiology Course Scheduled

The fifth annual Postgraduate Course in Anesthesiology will be offered on October 13 by the department of anesthesiology at the University of Louisville School of Medicine, according to Eugene H. Conner, M.D., chairman of the department.

Marion A. Carnes, M.D., professor of anesthesiology at the University of Kentucky College of Medicine, will discuss "Toxic Reactions to Local Anesthetic Agents" and "Epidural and Caudal Anesthesia" at the session, which will last from 9:00 a.m. to 4:30 p.m. Others on the faculty for the course will be members of the U. of L. anesthesiology department.

IN KENTUCKY

AUGUST

21-22 KAGP Bluegrass Seminar, Imperial House, Lexington

SEPTEMBER

21-23 KMA ANNUAL MEETING, Convention Center, Louisville

OCTOBER

1-2 Symposium on *Potassium and the Heart*, University of Kentucky Medical Center, Lexington

7 KAGP Maysville Seminar, Mason County Health Department, Maysville

13 Postgraduate Course in Anesthesiology, University of Louisville Medical Center

21 KAGP Symposium on Industrial Medicine, Stouffer's Louisville Inn, Louisville

NOVEMBER

15-19 Postgraduate Course #7, American College of Physicians, Pathophysiological Basis of Therapeutic, University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

AUGUST

22-27 American Academy of Physical Medicine and Rehabilitation, Sheraton Hotel, Philadelphia

22-27 Flying Physicians Association (11th Annual), Deauville Hotel, Miami Beach

30-Sept. 2 American Hospital Association, San Francisco

SEPTEMBER

9-11 American Association of OB-GYN, Homestead, Hot Springs, Virginia

10-12 American Academy of Pediatrics (District II of New York State), Concord Hotel, Kiamesha Lake, New York

10-12 National Conference on Physicians and Schools (10th), Sheraton-Chicago Hotel, Chicago

14-17 American Association of Blood Banks, Americana Hotel, Bal Harbour, Florida

16-18 International Cardiovascular Society (7th Congress), Bellevue-Stratford Hotel, Philadelphia

17-19 American Academy of Pediatrics (Pennsylvania State Chapter), Bedford Springs Hotel, Bedford, Pennsylvania

19-24 Michigan State Medical Society (Centennial Session), Sheraton-Cadillac Hotel, Detroit

21-24 Pennsylvania Medical Society, Chalfonte-Haddon Hall, Atlantic City, New Jersey

27-28 Tennessee Valley Medical Assembly, Tivoli Theater, Chattanooga

OCTOBER

7-8 Central Association of OB-GYN, Netherland Plaza Hotel, Cincinnati

10-13 Medical Society of Virginia, John Marshall Hotel, Richmond

11-13 Academy of Psychosomatic Medicine, Sherman House, Chicago

11-14 Second Postgraduate Course on Fractures and other Injuries, Riviera Motel, Atlanta, Georgia

12-14 Indiana State Medical Association, Murat Temple, Indianapolis

15-19 American Heart Association, Americana Hotel, Bal Harbour, Florida

18-22 American College of Surgeons Annual Clinical Congress, Dennis Hotel, Atlantic City, New Jersey

23-28 American Academy of Pediatrics, Palmer House, Chicago

29-30 Symposium on Common Problems in General Practice-Office Procedures, Mound Park Hospital Foundation, Florida

Academy of General Practice, 16th Annual Scientific Session, St. Petersburg



when a change in environment overwhelms him with anxiety

Foiling heolth, finonciol difficulties, or the death of a spouse ore omong the reasons why elderly people moy be obliged to leave their familior surroundings. Moving in with children or entering a home for the aged may satisfy practicol requirements but can be psychologicolly troumotic since emotionol resilience tends to diminish with oge.

Even when anxiety reaches overwhelming proportions, you can counteract it promptly with the potent tranquilizer—Atarax (hydroxyzine HCl).

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for any age—for any stage of anxiety

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Side effects and precautions: The transitory drowsiness which may occur with hydroxyzine HCl usually disappears spontaneously in a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with higher doses. Involuntary motor activity has been reported in hospitalized patients on higher than recommended doses. Hydroxyzine HCl may potentiate CNS depressants, narcotics such as meperidine, barbiturates, and anticoagulants. In conjunctive use, dosage for these drugs should be decreased. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Solution Precautions and contraindications:** This dosage form is intended only for I.M. or I.V. administration and should not, under any circumstances, be injected subcutaneously or intraarterially. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been rare. I.V. administration should be slow, no faster than 25 mg. per minute, and should not exceed 100 mg. in any single dose. Particular care should be used to insure injection only into intact veins; a few instances of digital gangrene occurring distal to the injection site have been attributed to inadvertent intraarterial injection or periarterial extravasation, both of which should be avoided. **More detailed professional information available on request.**

NEWS ITEMS

Keath E. Hammon, M.D., Louisville general practitioner, won all five titles in the seventh annual West Kentucky Championship and Jackson Purchase Open Skeet Shoot in Mayfield last month. It was his third straight overall title.

B. B. Montgomery, M.D., Paint Lick, has announced that he will move his general practice to Lancaster in the near future. He practiced there before going to Paint Lick.

Robert E. Amis, M.D., who has been a surgeon in Louisville for the past year, has announced that he will close his office in order to take a missionary post in Nigeria to which he was appointed recently by the Southern Baptist Foreign Mission Board. He is a 1959 graduate of the University of Louisville School of Medicine.

Joseph P. Holt, M.D., professor of heart research at the University of Louisville School of Medicine, left early last month for a summer at the University of California's Veterinary School, where he will study the right ventricle of large mammals. His research is supported by the Louisville and Jefferson County Heart Association, the American Heart Association, and the National Heart Institute.

W. H. Parker, M.D., Owensboro, has announced his retirement from active practice on June 15. An obstetrician and gynecologist, he has practiced in Owensboro for many years.

John P. Longstaff, M.D., has become associated with the Henderson Clinic, Henderson, Ky., for the part-time practice of psychiatry. A 1960 graduate of the University of Louisville School of Medicine, Doctor Longstaff completed his residency training at the University of Kentucky Medical Center and the Lexington Veterans Hospital. He also maintains an office in Evansville.

Carroll E. Howard, M.D., has opened an office in Owensboro, where he will limit his practice to pediatrics. He received his M.D. degree in 1961 from St. Louis School of Medicine, and interned at Cardinal Glennon Hosptial. His residency training was completed at the University of Tennessee Medical Center Hospital in Memphis.

'K and the Heart' Symposium Set

A two-day symposium on Potassium and the Heart, featuring 25 guest speakers of outstanding national and international standing, has been scheduled to be held at the University of Kentucky Medical Center October 1 and 2.

The symposium will be sponsored by the University of Kentucky and the Indiana University medical schools, the Kentucky Heart Association, and the Krannert Heart Research Institute. *Advance registration is necessary*. For information write to Borys Surawicz, M.D., Director, Division of Cardiology, U. of K. Medical Center, Lexington, Ky. 40506.

U. of L. Honor Graduate Dies

Jack G. Wallace, M.D., a member of the 1963 graduating class at the University of Louisville School of Medicine, died July 2 at Barnes Hospital, St. Louis, where he was a resident in internal medicine. He also interned at Barnes.

Doctor Wallace, who had been ill for the past few months, graduated with top honors in his class. His wife, Margaret ("Sudie"), was secretary to the KMA Executive Secretary for three years. Doctor Wallace was a native of Webster County.

KMA Council and Committee Reports

KMA Rural Health Committee

Donald L. Graves, M.D., Frenchburg, Chairman

KMA Headquarters Office **Thursday, May 13, 1965**

The Committee heard a report by its chairman and Joseph Hamburg, M.D., of the University of Kentucky faculty, on the National Rural Health Conference held earlier in May in Miami. G. L. Simpson, M.D., Greenville, chairman of the Governor's Advisory Council on Medical Care, was a participant at this National Conference.

The Committee also discussed a possible survey on career needs in the health field and how these needs might be met. The proposed draft for updating the Rural Health Council Brochure was reviewed, and plans for KMA participation in the 1965 Kentucky Rural Health Conference were explained.

School Health Committee

O.B. Murphy, M.D., Lexington, Chairman

KMA Headquarters Office **Thursday, May 13, 1965**

Greater improvements in the state school system's physical fitness program received considerable discussion during the recent KMA School Health Committee meeting at KMA Headquarters Office.

Members also discussed the committee's activities of the past and outlined future plans. Great emphasis was placed on stimulating PTA groups, school people, parents, etc., to become more interested in physical fitness of children. It was recommended that each county medical society appoint a school health chairman who will be a liaison representative with the KMA School Health Committee and the local Board of Education on matters of physical education and sports and its relationship to health.

Plans also were made for the AMA's "Medical Aspects of Sports" display to be exhibited at the 1966 KEA meeting.

Committee on Medicine and Religion

Joseph H. Saunders, M.D., Lexington, Chairman

KMA Headquarters Office **Wednesday, June 16, 1965**

Activities in the area of medicine and religion relationships throughout the state were reviewed in detail. These included a Trustee District meeting in the Sixth District at Bowling Green, special activity in Fayette County, and at the University of Kentucky College of Medicine.

Plans for having a medicine and religion booth at the KMA Annual Meeting were set, and arrangements were made for the committee to have a session during the Annual Meeting.

Committee to Study the Constitution and Bylaws

Robert S. Dyer, M.D., Louisville, Chairman

KMA Headquarters Office **Wednesday, June 16, 1965**

The Bylaws Committee reviewed the operation of the orientation program and made certain procedural recommendations to the Board of Trustees.

A number of recommendations of minor nature for bylaw changes were considered and acted on by the committee. These proposals will be introduced at the 1965 meeting of the KMA House of Delegates.

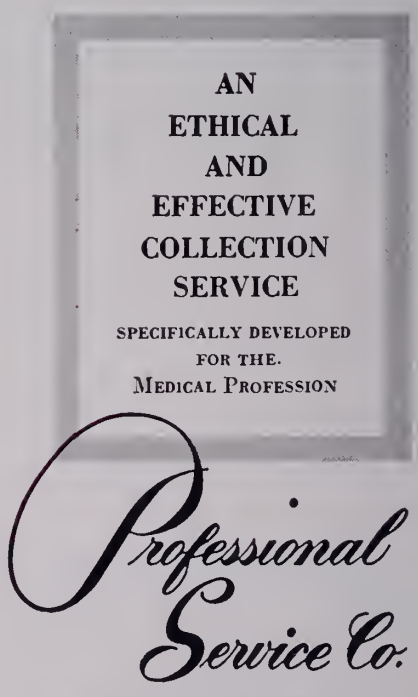
KMA Memorials Commission

Carlisle Morse, M.D., Louisville, Chairman

KMA Headquarters Office **Thursday, June 10, 1965**

The commission heard a report that members of the Board of Trustees had bought twenty-five chairs for the Board room, and that appropriate plaques had been inscribed and affixed to the chairs, bearing the name of the donors.

Plans were made for the development of the library-museum in the president's office at the headquarters office. This program is financed by contributions from past presidents, and $1,100 has been accumulated in this special fund.





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Gaucher's Disease

(Continued from Page 580)

Persons observing him could offer no explanation for his rapid respiration, cyanosis and dyspnea but suspected he may have had infarcts in the liver and lungs.

Autopsy permission was not granted.

Summary

Two cases of Gaucher's disease are reported in brothers who have been followed fifteen years after onset, and brief mention of a cousin who is alive at the age of fourteen years, all of whom had splenectomies and manifested typical bone findings.

All laboratory studies, including review of the bone marrow slides, revealed classical Gaucher's disease.

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2. Stransky, Eugene & Davis-Lawas, Domiciana F.: *Heredity in Infantile Type of Gaucher's Disease, Report of a Case,* Am. J. Dis. Child. 78:694, 1949.
3. Stein, Marvin, A. B. & Gardner, Lytt I., M.D.: *Acute Infantile Gaucher's Disease,* Pediatrics, 27:491, 1961.

Care of the Hemiplegic

(Continued from Page 582)

ten slow down the social adjustment and require supportive therapy.

7. Bowel and bladder training is carried out by a strict schedule. This also plays a large part in the social adjustment of the patient. The control aids in the prevention of decubiti and in the total rehabilitation of the individual.

Summary

The return of function of the hemiplegic individual should no longer be left up to the whims of nature. It is not enough to wait for only muscular power to return, because without functional ability, muscular power is useless. As muscular power returns, functional return is aided by proper therapy. It is a long-term affair and motivation must be ever present.

* * *

So far this year 448 new, active cases of tuberculosis have been reported to the Kentucky State Department of Health. At the same time last year 464 cases had been reported. *Lifelines,* monthly publication of the Kentucky TB and RD Association. June, 1965.

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Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
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Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

*Swartz, C., et al.: Circulation 28:1042, 1963.

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COUNTY SOCIETY REPORTS

Allen

V. E. Scherer, M.D, is currently serving as president of the Allen County Medical Society, according to recent information. Assisting Doctor Scherer in office are O. L. Davis, M.D., vice-president; F. J. Halcomb, Jr., M.D., secretary-treasurer; Earl P. Oliver, M.D., delegate to KMA; and John Hall, M.D., alternate delegate All the officers are from Scottsville.

Caldwell

Frank P. Giannini, M.D., took office July 1 as president of the Caldwell County Medical Society, according to a recent secretary's report. Other officers for 1965-66 are: B. G. Jackson, M.D., vice-president and president-elect; N. H. Talley, M.D., secretary-treasurer; and Ralph Cash, M.D., delegate to KMA. Doctor Jackson is also alternate delegate to KMA. All are from Princeton.

Edmonson

M. B. Wilkes, M.D., is the new president of the Edmonson County Medical Society, it was recently announced. Doctor Wilkes will also serve as alternate delegate to KMA. S. E. Farmer, M.D., secretary-treasurer for the current year, will serve as delegate. Both are from Brownsville.

Grayson

A. L. Embry, M.D., Millwood, is serving this year as president of the Grayson County Medical Society. Patrick A. O'Neill, M.D., Leitchfield, is vice-president, and Clyde J. Nichols, M.D, Clarkson, secretary-treasurer. Ralph G. Thomas, M.D., Leitchfield, and Charles L. Bland, M.D., Leitchfield, will serve as delegate to KMA and alternate delegate, respectively.

Harrison

K. W. Brumback, M.D., is 1965 president of the Harrison County Medical Society, according to recent information. Joseph M. Withers, M.D., is vice-president, and Don R. Stephens, M.D., is secretary-treasurer and alternate delegate to KMA. Henry H. Moody, M.D., will serve as delegate. All are from Cynthiana.

Monroe

William F. Bushong, M.D., Tompkinsville, is president of the Monroe County Medical Society for 1965, it has been reported. Other officers are: Wendell F. Hurt, M.D., Tompkinsville, vice-president; J. Jack Martin, M.D., Tompkinsville, president-elect; Kenneth R. Crabtree, M.D., Gamaliel, secretary-treasurer; John C. Marsh, M.D., Gamaliel, delegate to KMA; and Jimmy Carter, M.D., Tompkinsville, alternate delegate.

Rowan

Everett D. Blair, M.D., is the new president of the Rowan County Medical Society, it was recently reported. Other officers for 1965 are: George C. Barber, M.D., vice-president; F. Calvin Bigler, M.D., secretary-treasurer; S. E. Reynolds, M.D., delegate to KMA; and B. J. Caudill, M.D., alternate delegate. All are from Morehead.

Spencer

William K. Skaggs, M.D., Taylorsville, will serve as president of the Spencer County Medical Society for 1965, it was announced. He is also alternate delegate to KMA. M. H. Skaggs, M.D., also of Taylorsville, is secretary-treasurer of the Society, and will serve as its delegate to KMA.

Washington

Dixie E. Snider, M.D., Springfield, took office July 17 as president of the Washington County Medical Society, it has been announced. Other officers are: Charles Howard, M.D., vice-president; H. B. Simms, M.D., secretary-treasurer and delegate to KMA. Doctor Snider will serve as alternate delegate.

Woodford

Francis Willey, M.D., Versailles, is president of the Woodford County Medical Society for this year. Doctor Willey will also serve as delegate to KMA from the Society. Lewis E. Wash, M.D., Lawrenceburg, is vice-president and president-elect, and will be alternate delegate. William J. Graul, M.D., Versailles, is secretary-treasurer.

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Contraindications: Pregnancy; leukemia, lymphoma and other generalized malignancies; brain damage in children under one year of age; febrile illness; allergy to egg proteins, neomycin, or streptomycin. Precautions: Use cautiously in patients with a history of tuberculosis and patients being treated with steroids, irradiation, alkylating agents, and antimetabolites. Consult package literature before administering Lirugen.

References:
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AMA House of Delegates Considers Federal Health Care Legislation, Other Important Matters, at 1965 Annual Meeting in New York

Federal health care legislation, the report of the President's Commission on Heart Disease, Cancer and Stroke, The Gunderson Committee report on organization of the House of Delegates, and a plan for a new method of establishing AMA scientific sections, were among the major subjects acted upon by the House of Delegates at the American Medical Association's 114th Annual Convention held June 20-24 in New York City.

Final registration figures reached a grand total of 64,517, including 24,268 physicians, the largest physician registration in the Association's history.

Health Care Legislation

Most controversial issue before the House was that of nonparticipation under any so-called "Medicare" law that might be passed by Congress. This subject came up in various ways in nine resolutions and in portions of Doctor Appel's inaugural address.

The House recommended that "the members of the American Medical Association be reminded that it is each individual physician's obligation to decide for himself whether the conditions of a case for which he is about to accept responsibility permit him to provide his own highest quality of medical care."

In adopting a substitute resolution, the House declared that "the physicians of the United States of America pledge themselves to continue their search and activity, in whatever social environment may develop, to secure or to restore the freedom, high quality and availability of medical care which has been traditional in our country.

"When the fate of the pending medicare legislation is determined, this House will review, in special session if necessary, the effect of the law and take whatever action is deemed necessary.

"In keeping with the testimony before your Committee, and the expressed policies of this House, this action should in *no way* be interpreted as a change in Section 6 of the "Principles of Ethics" of the American Medical Association which plainly states: "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care"; and that this House of Delegates reaffirms the principles of the Bauer amendment adopted in 1961.

"The House of Delegates reaffirm the nine principles for standards of health care programs as adopted by the House of Delegates in its special meeting February 7, 1965, and amended to read as follows:

'(1) No person needing health care shall be denied such care because of the inability to pay for it.

'(2) It is appropriate that government revenues be used to finance health care when other resources have been found to be inadequate.

'(3) Every level of government, municipal, county, state and federal, should assume a responsible share in the financing of such programs.

'(4) The health care provided by such programs should be adequate and should be equal to that available to those who can afford to pay.

'(5) Maximum use should be made of voluntary prepayment and insurance mechanisms.

'(6) Administration of such program should be the responsibility of the state government. Participating states should be required to meet adequate standards of administration in order to qualify for federal funds.

'(7) Eligibility requirements for benefits should be fair, realistic, uncomplicated and practical.

'(8) Any such health care programs should provide funds only, and not direct services.

'(9) Funds for such programs may come from general tax revenues and not from social security taxes' "

Offer to President Johnson

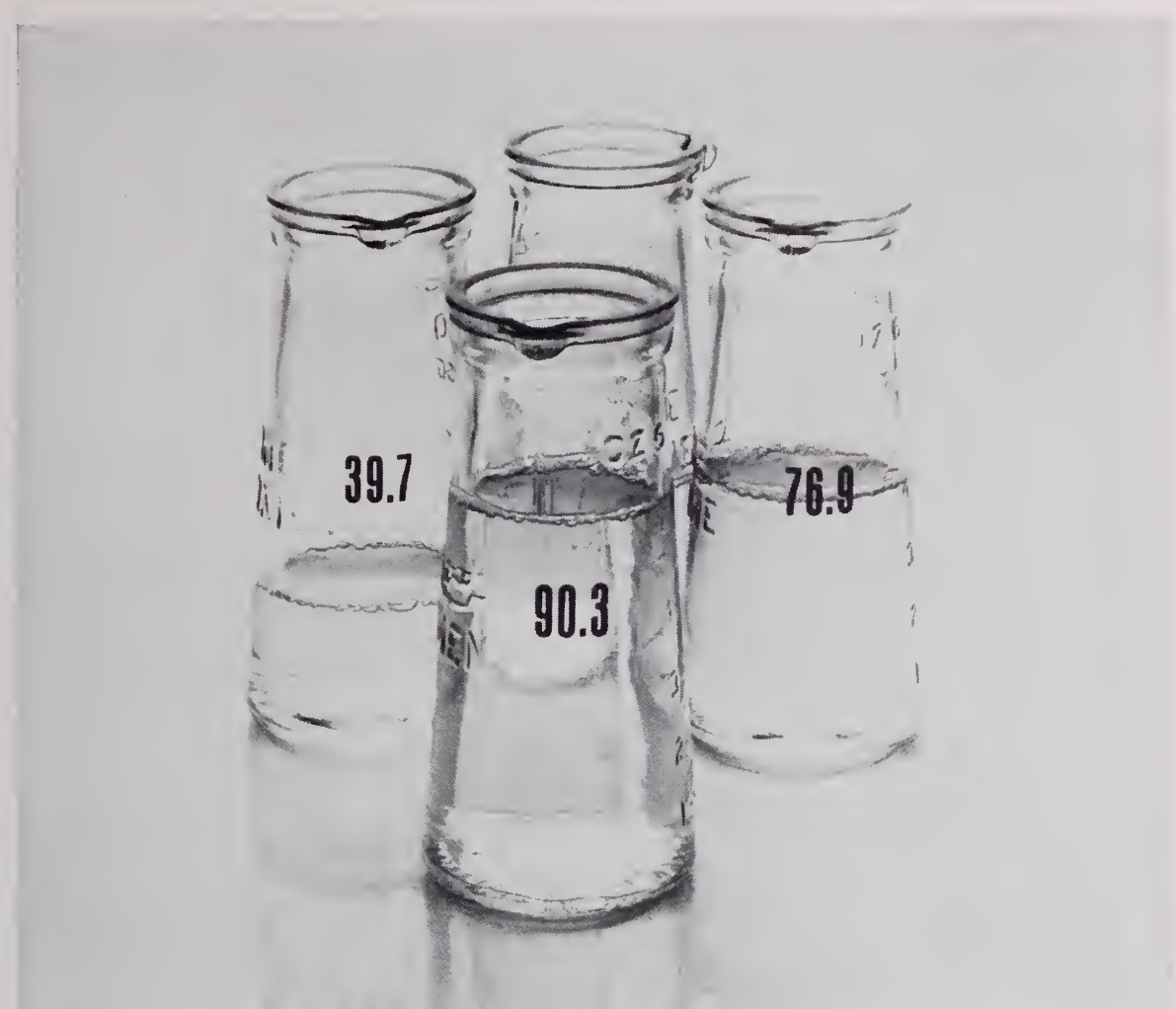
In a related action, urging that government seek the advice of the medical profession on health legislation, the House adopted a resolution which included the following statements:

The House of Delegates restate its offer to meet with the President of the United States through our Legislative Task Force to discuss proposed medical care legislation with a view of safeguarding the continued provision of the highest quality and availability of medical care to the people of the United States.

"This House of Delegates of the American Medical Association instruct the Board of Trustees of the American Medical Association to embark immediately on an active campaign to inform the membership of the American Medical Association of the grave considerations in adhering to our principles of ethics posed by legislation now pending before Congress.

"The American Medical Association strongly urge those branches of the government interested in the formulation, the enactment, and the implementation of laws which deal with the provision of professional medical services to the public to seek and utilize the advice and assistance of the physicians who will render such services. Such advice and assistance should be received through our chosen representatives, the officers of the American Medical Association.

"The American Medical Association intensify its efforts to modify all such pertinent legislation, employing the necessary means and appropriate actions to the end that the health of the public and the pursuit of excellence in medicine be unimpaired by such legislation.



approximating the diuretic efficacy of meralluride

METAHYDRIN®
(trichlormethiazide)

To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

"The American Medical Association make every effort to continue, and where necessary, to expand its communication activities so that all physicians as members of component medical societies will be promptly, continuously and completely informed of developments in this critical area during the coming months."

The DeBakey Commission Report

In considering seven resolutions involving the report and recommendations of the President's Commission on Heart Disease, Cancer and Stroke, the House adopted a substitute statement which resolved that:

"The American Medical Association point with pride to the immense strides made in the approaches to the conquest of heart disease, cancer, and stroke under existing patterns of research and medical practice; strongly favoring the use of available financial support for extension of these patterns rather than replacement by a complex of medical control centers and satellites.

"The American Medical Association oppose those particular Commission recommendations which call for and have stimulated proposals for hastily contrived and unproven sweeping changes in the pattern of medical research, education, and patient care.

"The component state medical associations be urged to conduct conferences with medical educators and scientists, medical staffs of hospitals, medical society representatives, and other interested parties, for the purpose of exchanging information and for the development of such recommendations as may be appropriate for the continued improvement of medical education, research and patient care.

"The state medical associations be urged to report findings and recommendations resulting from these conferences to the AMA Board of Trustees, for the information of the Board, its councils, and the Association members."

The Gundersen Committee

Action on the Gundersen Committee report reviewing the size, make-up and functions of the House of Delegates was postponed until the 1965 Clinical Convention in Philadelphia.

The House adopted a reference committee report saying:

"It was apparent that if the organization of the House of Delegates of the American Medical Association, which is of paramount importance to the efficient and productive operation of the Association, is to be thoroughly studied by the delegates, more time will be required."

The Gundersen Committee was appointed an ad hoc unit at the directive of the AMA House in June, 1963. The committee, which is chaired by Gunnar Gundersen, M.D., La Crosse, Wis., a past president of the AMA, brought in an extensive 35-page report.

The committee pointed out that certain aspects of its work were unfinished, particularly those dealing with the function of the AMA scientific sections. The AMA House action recommended that the committee continue its study of scientific sections.

Organization of a New Section

In a report to the Board of Trustees, the Council on Postgraduate Programs affirmed its belief that the establishment of a new section is an important change in the AMA structure, and submitted a procedure for evaluating the qualifications for a new section and the scientific programs of all sections.

In brief, this procedure provides that (1) the group requesting formation of a new section submit to the Executive Vice President a written request for approval; (2) the request be transmitted by the Board to the Council on Postgraduate Programs for evaluation of the petition; (3) if approved by the Council, a mandatory trial period of two years as presently in effect be provided under the auspices of the Council; and (4) after such trial period, a recommendation for acceptance or denial of the petition for the establishment of a section be made to the Board.

The House approved the recommendation, with certain word changes, and suggested that it be sent first to the Gundersen Committee and then to the appropriate AMA council for consideration.

Miscellaneous Actions

In dealing with 73 resolutions and numerous reports from councils, committees and the Board of Trustees, the House of Delegates also:

Urged medical schools and agencies concerned with continuing education to incorporate "appropriate learning experiences" for physicians in counseling relating to sexual attitudes and behavior.

Agreed that hospital medical staffs and state and component medical societies be urged to encourage the establishment, maintenance, and proper use of cancer registries in hospitals, but that the establishment of such registries should not be made a requirement for accreditation by the Joint Commission on the Accreditation of Hospitals.

Instructed the Council on Medical Service and its Committee on Federal Medical Services to "remain alert to any deviations from policies of the Veterans Administration concerning the provision of drugs to veterans treated by private physicians, and to meet with pharmacy representatives so that the basic principle of freedom of choice" of pharmacists be maintained.

Referred to the Board of Trustees a resolution calling for the AMA to caution the public against discontinuing voluntary health insurance policies and prepayment plans for persons over 65 in "anticipation of pending legislation."

Reaffirmed its policy concerning the practice of radiology, pathology, anesthesiology and physical medicine in hospitals.

Reaffirmed AMA policy that human blood, as living tissue, should not be purchased under insurance contracts. It was recognized that exceptions may be necessary when there is need for unusually large numbers of transfusions, or whenever volunteer blood donors are not available.

Urged state and local medical societies to encourage the development of the Explorer Scout Pro-

a rapid lift from the hell of depression



Doré Illustration
from
Dante's Inferno

often relieves mental pain in 2-5 days

NORPRAMIN®
(desipramine hydrochloride)

Norpramin is a rapid-acting specific drug for the treatment of depression. Depressive signs and symptoms—sometimes described as "mental pain"—typically begin to improve in 2-5 days. Patients are more hopeful, less empty and less weighed down by their troubles. Norpramin has only slight sedative qualities, nevertheless anxiety *secondary to depression* is frequently relieved as depression is lifted. If anxiety or tension persists it can be controlled by adding a tranquilizer or by reducing dosage. Norpramin is not a MAO inhibitor. Side effects are usually mild.

DOSAGE AND ADMINISTRATION

Optimal results are obtained at a dosage of about 150 mg./day—two 25 mg. tablets t.i.d. After achieving optimal results, a maintenance dose (50-100 mg./day) should be sought.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

IN BRIEF:

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

Contraindications and Precautions: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established.

Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

Supplied: Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

gram for Medical Specialty Posts and noted that about 150 of the 21,000 Explorer Scout posts in the country are directly related to health.

Adopted a resolution calling for continued efforts to secure the passage of legislation "which will remove tax discrimination against professional people, specifically HR 10 (Keogh) and HR 697 (Weltner), but turned down recommendations that the AMA encourage its members to proceed at the state and county levels with the formation of corporations for the purpose of implementing an "organized effort in the courts to remove tax discrimination."

Directed the Board to review the subject of federal assistance for operating expenses for health or medical education facilities.

Directed the Board to study the opportunities and problems associated with Operation Head Start and other programs now operating or planned under the Economic Opportunity Act.

Referred to the Board for study a resolution calling for "a program of purchase of health insurance . . .in every state, subsidy for which shall be by federal-state participation," under which "extension of coverage shall be to all needy persons regardless of age."

Also referred to the Board for consideration and appropriate action a 10-point legislative program outlined by the Minnesota delegation.

Received a series of resolutions urging approval of an American Board of Family Practice. All were referred to the Council on Medical Education.

Urged the Council on medical education to establish a standard date of appointment for all approved residency training programs.

Encouraged state and county medical societies to participate in the formation of State Associations of the Professions, "to provide a vehicle, for interprofessional cooperation in those areas where united activity of the various professions can be of great benefit."

Amended the bylaws to provide that the vice president shall succeed to the presidency should the president die, resign or be removed from office.

Accepted a Board of Trustees report stating that it had referred to the joint AMA-American Bar Association committee a previously introduced resolution designed to present a grievance against alleged abuse of legal processes, characterized in the resolution as "vexatious litigation."

Opening Session

Dr. Appel, expressing his personal opinion in his inaugural address at the Sunday session, said that if the omnibus Medicare bill is passed by Congress, the medical profession must do all it can to develop the good points and eliminate the bad points of the law. He declared that, regardless of personal opinion, "we do not have the right—either as physicians or citizens—to violate a law or to violate the spirit of the law or its intent." Outgoing President Donovan F. Ward pointed out:

"If it were true that the public climate was the dominant factor affecting the decisions of those who make legislative history, we now would be winning both in the House and the Senate."

EDITOR'S NOTE: *A full list of all elected officials at the New York meeting is available at he KMA Headquarters Office on request.*

WA-KMA Past Presidents

(Continued from Page 611)

*1936—Mrs. Ernest Arthur Barnes, Albany
*1937—Mrs. Stephen C. McCoy, Louisville
*1938—Mrs. Harlan Usher, Sedalia
1939—Mrs. Reasor T. Layman, Elizabethtown
1940—Mrs. John M. Blades, Butler
*1941—Mrs. John G. South, Frankfort
1942—Mrs. John B. Floyd, Richmond
1943—Mrs. Octavus Dulaney, Louisville
*1944—Mrs. Eleanor Hume Offutt, Frankfort
1945—Mrs. Shelby Carr, Richmond
1946—Mrs. Elmer L. Henderson, Louisville
1947—Mrs. Walker Owens, Danville
1948—Mrs. R. Haynes Barr, Owensboro
1949—Mrs. Elbert W. Jackson, Paducah
1950—Mrs. Clark Bailey, Harlan
1951—Mrs. John S. Harter, Louisville
1952—Mrs. David Woolfolk Barrow, Lexington
1953—Mrs. Clyde C. Sparks, Ashland
1954—Mrs. Karl D. Winter, Louisville
1955—Mrs. R. Ward Bushart, Fulton
1956—Mrs. Charles B. Stacy, Pineville
1957—Mrs. J. Andrew Bowen, Louisville
1958—Mrs. Jesse T. Funk, Bowling Green
1959—Mrs. Charles B. Johnson, Russell
1960—Mrs. Earl W. Roles, Louisville
1961—Mrs. Guy Morford, Owensboro
1962—Mrs. James Sears Rich, Lexington
1963—Mrs. J. Murray Kinsman, Louisville

* *Deceased*

In Memoriam

HORACE HANSBOROUGH SEAY, M.D.

Louisville, Ky.

1899 - 1965

Horace H. Seay, M.D., 65, Louisville general practitioner for many years, died June 21 in Louisville. A native of Eastwood, Ky., Doctor Seay was graduated from the University of Louisville School of Medicine in 1925. He was a veteran of World War I and World War II, and a member of the KMA, AMA, and Jefferson County Medical Society.

CHARLES PATTERSON SHIELDS, M.D.

Paducah, Ky.

1899 - 1965

Charles P. Shields, M.D., a physician and surgeon in Paducah for 24 years, died Sunday, July 11 at his home in that city. Doctor Shields had practiced in Glasgow for ten years following his 1931 graduation from the University of Louisville School of Medicine. In addition to membership in KMA and AMA, he was a member of the Southern Surgical Association.

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: ACTIONS AND USES: A single dose of Imteron (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imteron (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imteron (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

in iron deficiency anemia for rapid and predictable replacement of iron reserves

imferon®

(iron dextran injection)



LAKESIDE LABORATORIES, INC. • Milwaukee, Wisconsin 53201

IN THE BOOKS

MANAGEMENT OF THE PATIENT WITH SUBNORMAL VISION: by Gerald Fonda, M.D.; Published by C. V. Mosby Company, St. Louis, 1965; 147 Pages; Price, $11.00.

Doctor Fonda has produced a very practical and concise presentation of the evaluation and management of the patient with subnormal vision. This is an area often poorly understood and neglected by many ophthalmic practitioners. The author's common sense approach to the clinical applications of optical and visual aids is most rewarding reading. Theoretical optics is de-emphasized. Many time-honored concepts of correction of subnormal vision, such as the over-rated value of telescopic lenses, are placed in their proper perspective.

An excellent section deals with evaluation of the partially sighted patient in regards to suitability for training in small type, large type or Braille reading. Misconceptions of the value of large type reading material are underscored.

The primary value of this book, however, is to guide the refractionist in the proper choice of the optical device to best enable the patient with subnormal vision to read.

This timely book is recommended for every practicing ophthalmologist and is of value to those educators involved in training of the partially sighted.

THOMAS E. CAMPBELL, M.D.

SIMPLE SPLINTING: The Use of Light Splints and Related Conservative Therapy in Joint Diseases: by Jerome Rotstein, M.D.; Published by W. B. Saunders Company, Philadelphia, 1965; 126 Pages; Price, $6.50.

This book is a presentation of techniques considered useful for the immobilization of actively inflamed or deformed joints in patients with rheumatoid arthritis. Although the book's title and subtitle—"Simple Splinting. . .in Joint Diseases" suggest that the book covers all forms of rheumatic diseases, the therapeutic recommendations are limited solely to rheumatoid arthritis.

The book's content is divided into six chapters followed by a brief index. The main body of the book (Chapter 4), composing approximately half of the book, is concerned with specific techniques in splint making. The opening chapter, executed by Doctor Rotstein's talented wife, is a clearly written and interesting account of historical information related to the treatment of arthritis. Chapter 2 is a description of a practical conservative regimen for rheumatoid arthritis. Chapter 3 briefly reviews certain pertinent knowledge concerned with the anatomy of joints. Chapter 5 is a compendium of information on materials for making splints and lists commercial sources for obtaining the materials. The final chapter deals with Doctor Rotstein's evaluation of selected pharmacologic agents for treating rheumatoid arthritis.

In the major section of the book the author skillfully outlines in "cook book style", with the aid of many illustrations, the details of how to prepare splints to prevent and/or correct disabling features resulting from rheumatoid arthritis. Doctor Rotstein properly stresses the importance of preventing serious and disabling flexion contractures of the knee. Although he advocates long-legged (night) resting splints made from plaster of Paris, others, including this reviewer, prefer lightweight splints fabricated from thermoplastics, which can be "made to measure" from a plaster mold of the patient's involved lower extremities. Although plastic splints are more costly, the greater durability and comfort obtained outweigh the initial greater financial outlay. Patient acceptance is a significant aspect since this appliance will obviously not be of benefit unless it is worn regularly. Twenty-three (23) pages are devoted to useful "cock-up" splints to combat dysfunctions of the wrists and thumb.

The final chapter covers the use of therapeutic agents in rheumatoid arthritis, including salicylates, antimalarials, phenylbutazone, gold therapy and corticosteroids. Newer anti-inflammatory compounds, such as oxyphenbutazone (Tandearil) and Indomethacin are not discussed. Since the major purpose of this volume is to describe conservative and preventative therapy, emphasizing the role of splinting to protect and rest sick joints, the section on drug therapy is held to a minimum. Doctor Rotstein differs with the expressed opinion of some rheumatologists that early signs of gold toxicity frequently beget and herald in a remission. The author gives short shrift to corticosteroids and only alludes to the newer synthetic analogs. Most experienced workers in the field would disagree with his statement. . ."none of the newly developed steroids. . . have any advantage over prednisone". Prednisone's capacity for causing some sodium and fluid retention in susceptible patients would be one significant drawback. His admonition that a maintenance dosage of 5 mg of prednisone produces no adverse reactions would also provoke disagreement among some investigators. I have seen serious untoward side effects arise in patients receiving less than 5 mg of prednisone.

Some minor errors have crept into the text—a few are typographical; aspirin was introduced into practice in 1895, not 1899; Chloroquine was synthesized in 1934, not 1943. The lack of reference numbers correlated with the body of the text in the

(Continued on Page 646)

when even southern sun fails to warm cold hands and feet

provide rapid, sustained vasodilation for warmth and relief of pain, dizziness and faintness in patients with impaired peripheral circulation

GERILIQUID warms cold hands and feet through the thermogenic action of glycine and through sustained vasodilation by glycine and niacin. In addition, in patients with impaired peripheral circulation, GERILIQUID increases the ability to walk farther with less pain. Patients particularly like the palatable, sherry wine base.

Geriliquid®



IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.

Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.

Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.

Supplied: Bottles of 8 oz. and 16 oz.

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #17-62. This 26 year old, married, white, gravida 6 para 5 was seen initially by a private physician on March 2, 1962. Her expected date of delivery was July 25, 1962. At her initial visit she weighed 113 pounds. The blood pressure was 140/90. The urinalysis was normal. The hemoglobin was 11.1 gm and the hematocrit 39%. According to her past history, she had four living children; her second child had died at the age of seven months. She had been hypertensive with all her pregnancies and had convulsions with her first pregnancy. Her last child was delivered in Dayton, Ohio without difficulty. Her largest baby weighed a little over 7 pounds.

The patient was seen on April 27 when she weighed 119½ pounds. the blood pressure was 150/90. She complained of slight headaches, and had noted slight swelling of the hands and feet toward the end of the day. The urinalysis showed a trace of albumin. Hygroton was prescribed, to be taken every other day. Her next visit took place on June 18, when the blood pressure was 160/110, and she weighed 127½ pounds. The uterus rose to 24 cm above the symphysis. The fetal heart beat was heard in the right lower quadrant. A urinalysis was negative. She was started on hydrodiuril 25 mg. daily and told to return in two weeks.

She returned on July 6 complaining of fever, chills, and pain in the right lower quadrant of the abdomen. The blood pressure was 160/90, and weight, 128 pounds. The urinalysis showed 2+ albumin. On auscultation of the chest, there were a few scattered moist rales over the apices. She was thought to have a respiratory infection; penicillin tablets were prescribed after an injection of Penstrep had been given. Hydrodiuril was continued in the prior dosage.

Four days later, on July 10, she was brought to the emergency room complaining of weakness with a tight feeling in her head, face, and extremities. She began to convulse while in the emergency room, and was immediately given sodium seconal while an airway was established. She was admitted and Serpasil 0.5 cc every 4 hours was ordered if the blood pressure exceeded 140/90. The blood pressure was 200/130, pulse 92. She complained of a severe headache and received 50 mg Demerol for the pain. Admission urinalysis showed 4+ albumin with 6-8 granular casts per field. She began to vomit at 11:00 A.M., and her blood pressure was rising. She had another convulsion beginning at 11:35 A.M. and lasting approximately five minutes; during this seizure she became incontinent of urine. She received 1.5 cc of sodium seconal intravenously, and stopped convulsing. Vaginal examination at this time showed the cervix to be closed.

The patient continued to have frequent convulsions throughout the day; temporary control was secured at intervals by administration of seconal. At 12:40 P.M., she received another 0.5 cc of Serpasil. At 2:35 P.M. she was given another grain of sodium seconal intramuscularly as her blood pressure was again elevated to 200/150. Following this medication, there was a decrease in the blood pressure. By 4:45 P.M., it was 164/138. She again convulsed and received another 1.5 cc of sodium seconal and 1 cc of Serpasil; nasal oxygen was started. In spite of this management, she had another convulsion lasting a few seconds at 5:20 P.M. The patient's temperature was slowly rising; at 6:45 P.M., it was 100.6°. At 6:55, she received 3 3/4 grains of sodium amytal intravenously slowly to try to control the convulsions, in addition to an ampule (2 cc) of magnesium sulfate in divided doses into each buttock.

She continued to have one convulsion after another and was sedated with seconal and amytal. At 9:35 P.M., she received another cc of Serpasil followed by 7½ gr sodium amytal at 10:00 P.M. Consultation was obtained from two other physicians, who had nothing to suggest besides keeping the patient well sedated and oxygenated. A Foley catheter was inserted to obtain a more exact intake and output record.

Vaginal examination at 10:55 P.M. showed the cervix to be 3 cm dilated. The membranes were stripped from the cervix, but they were not ruptured since the head was high. The patient was delivered spontaneously in the labor room at 12:20 A.M. on July 11, 1962 of a premature male infant weighing 4 pounds 6 ounces; the baby breathed immediately, but did not cry. The baby's airway was suctioned and he was placed in an incubator; he subsequently did well. The patient's blood pressure was still elevated to 170/140 at 2:00 A.M. She had received no ergotrate or pitocin. She was given another 0.5 cc of Serpasil. The nurse's notes indicated that her body and extremities were cool and there was little response to external stimuli, although she occasionally moved her arms. The oxygen was discontinued temporarily, but by 2:30 A.M. the nurse reported that her pulse was somewhat irregular, so the oxygen was restarted. By 3:30 A.M. she seemed more responsive to external stimuli; her blood pressure was 128/118. By 5:00 P.M., the pulse was 90, respirations 28, and blood pressure 158/130. She received another 0.5 cc of Serpasil. Around 8:10 A.M., she began grunting and her breathing became labored. Shortly thereafter, no blood pressure could be obtained. Her physician was called and found her breathing 8-10 times per minute; her pulse was 90 and very weak. She received artificial respiration, caffeine sodium benzoate, and oxygen under pressure with the anesthetic machine, all to no avail. She died at 9:10 P.M. Permission for autopsy was refused.

(Continued on Page 646)



more complete relief for the "dyspeptic"

DACTILASE®

Dactilase provides comprehensive therapy for a wide range of digestive disorders. Its antispasmodic and anesthetic actions rapidly relieve pain and spasm. Dactilase decreases hypermotility without inducing stasis. In addition, it supplies digestive enzymes to help reduce bloating, belching and flatulence. Dactilase does not interfere with normal digestive secretions. Very often it can be a most useful answer to the dyspeptic's needs.

DACTILASE: Each tablet contains: Dactil® (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylolytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

SMA Ophthalmologists to Meet

Algernon B. Reese, M.D., New York City, will be the guest speaker for the annual meeting of the Section on Ophthalmology of the Southern Medical Association, Philip M. Lewis, M.D., Memphis, chairman of the Section, announced. The meeting will be held in Houston November 1-4.

In The Books

(Continued from Page 642)

bibliographic listing is a somewhat annoying shortcoming.

In general these faults and critical comments are minor and do not seriously detract from the practical value of this work. The book can be highly recommended to any physician who may encounter and manage patients with this serious and potentially crippling rheumatic disorder.

The printing is easily readable in large type on a glossy heavy paper. The black and white photographs are excellent.

DAVID H. NEUSTADT, M.D.

Maternal Mortality

(Continued from Page 644)

The final diagnosis as reported on the death certificate was cerebral hemorrhage secondary to eclampsia.

Comment

The Committee believed this to be an example of a direct obstetric death with preventable factors on the part of the physician. The clinical picture was that of a patient with underlying hypertensive disease and superimposed eclampsia. The terminal event was probably a cerebral hemorrhage. The patient should have been hospitalized for workup on April 27 when the first signs of superimposed toxemia made their appearance. The repeated administration of barbiturates in an attempt to control the convulsions was ill-advised, as these drugs are known to aggravate further any pre-existing central nervous system hypoxia. There was a lack of systematic approach to the management of the eclamptic phase which may have contributed to the final outcome. Standard modern treatment of eclampsia includes the use of magnesium sulfate, an excellent central nervous system sedative. Some authorities continue to employ morphine in a modification of the classic Stroganoff regimen. In a patient with marked hypertension, one of the antihypertensive agents such as Unitensen or Apresoline may be of value in reducing the danger of a cerebrovascular accident. Serpasil has not proved to be an effective agent for the control of hypertensive complications of late pregnancy despite its proved usefulness in otherwise uncomplicated essential hypertension. The rarity of frank eclampsia in modern obstetric practice should not be allowed to induce unfamiliarity with the best empiric methods currently available for its management.

Pertinent Paragraphs

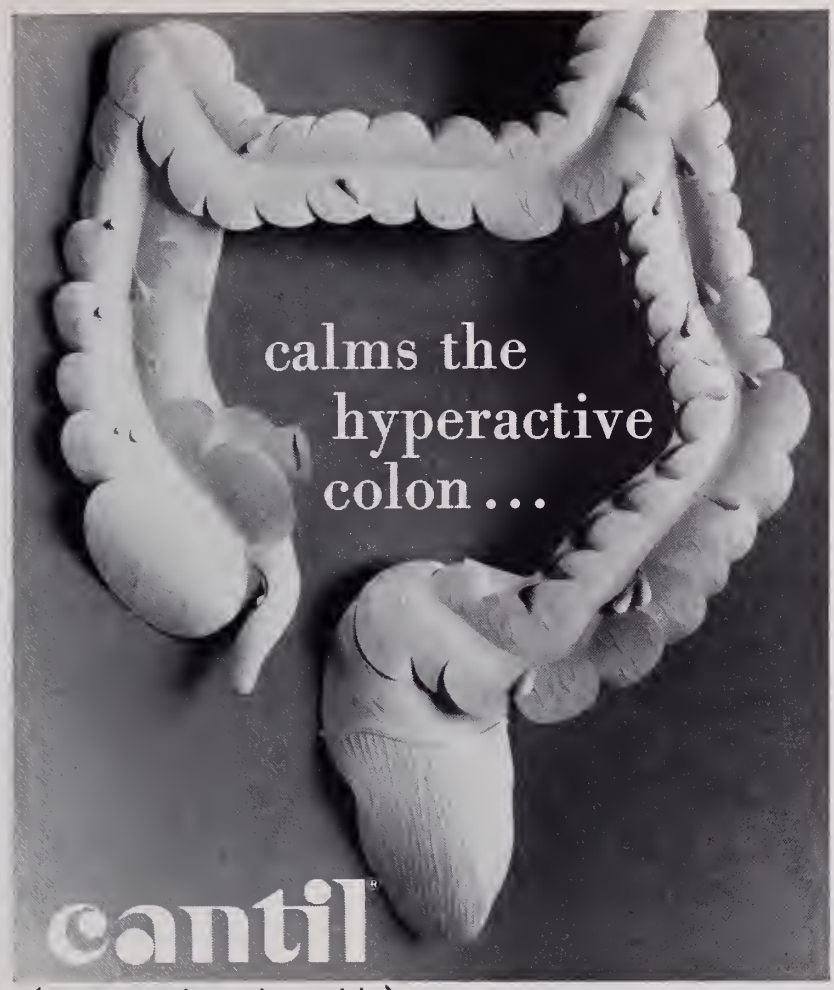
A special postgraduate course in laryngology and bronchoesophagology will be held September 20 to October 2 at the University of Illinois College of Medicine, Chicago. The course is sponsored by the College's department of otolaryngology. For information contact the Dept. of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, P. O. Box 6998, Chicago, Ill. 60680.

The Otolaryngologic Assembly of 1965 will be held October 30 through November 5 by the department of Otolaryngology of the University of Illinois College of Medicine. The assembly will be held in the new Illinois Eye and Ear Infirmary at the Medical Center, Chicago. For further information, contact: Dept. of Otolaryngology, College of Medicine of the University of Illinois, at the Medical Center, Chicago, P. O. Box 6998, Chicago, Ill., 60680.

All studies show clearly that (pharmaceutical) advertising is effective and that it is useful. Information is sought by physicians from the detail man, from journal advertising, and from direct mail advertising, usually in that order. Occasional nuisance though it may seem to be . . . it is clear that pharmaceutical advertising is much too important to be ignored as a factor in progress.—H. L. Hartley, M.D., in *Northwest Medicine,* 64: 1, (Jan.) 1965.

Almost 600 new basic chemical and biological drugs were developed in the last 30 years. In spite of plant expansion, labor costs and research expenses, pharmaceutical prices have gone down 13.8% since 1949 compared to a rise of 26.7% in the Wholesale Price Index of the Bureau of Labor Statistics. Being acutely aware of the attacks on the American pharmaceutical industry by our national government and its committees, it is interesting to note that if all drug advertising were eliminated, it would amount to a saving of some 5 cents on a dollar for a prescription item. This is one of the major things the Kefauver committee was trying to do. How the medical profession would be affected by such a restriction is hard to envisage and what it would do to the drug industry might well be catastrophic, unless, of course, the doctors were required to prescribe only from a government formulary as was tried by the government of Australia in 1949.—W. Albert Brewer, M.D., in *Arizona Medicine,* 22:2, (Feb.) 1965.

It is all very well for the profession and the public to be alert and alarmed at drug reactions, and to do everything in their power to keep these at a minimum. Nevertheless, to me . . . the pendulum has swung much too far in the other direction, to the extent that many individual members of the public, to my personal knowledge, are more concerned about nonexistent reactions than they are with the evident benefit they have obtained from the drug they are taking.—Irwin C. Winter, Ph.D., M.D., in *Journal of New Drugs,* 4:6, (Nov-Dec.) 1964.



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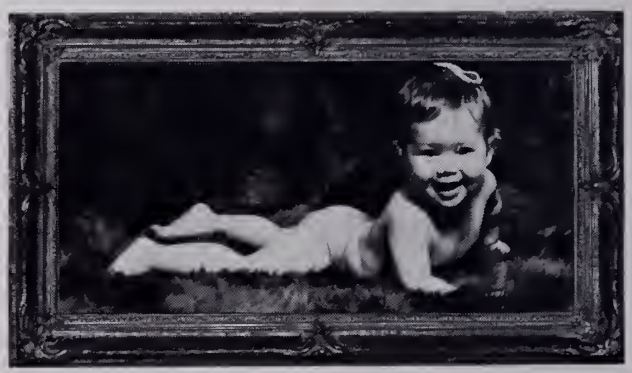
1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957
2—Asher, L.M.: Am. J. Digestive Diseases *4*:272 (Apr.) 1959

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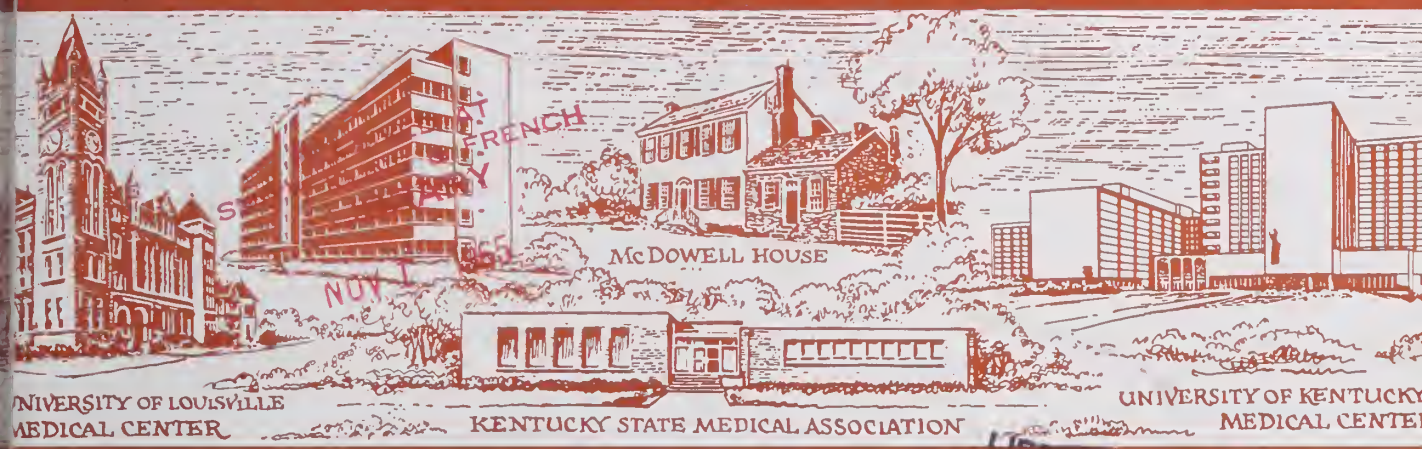
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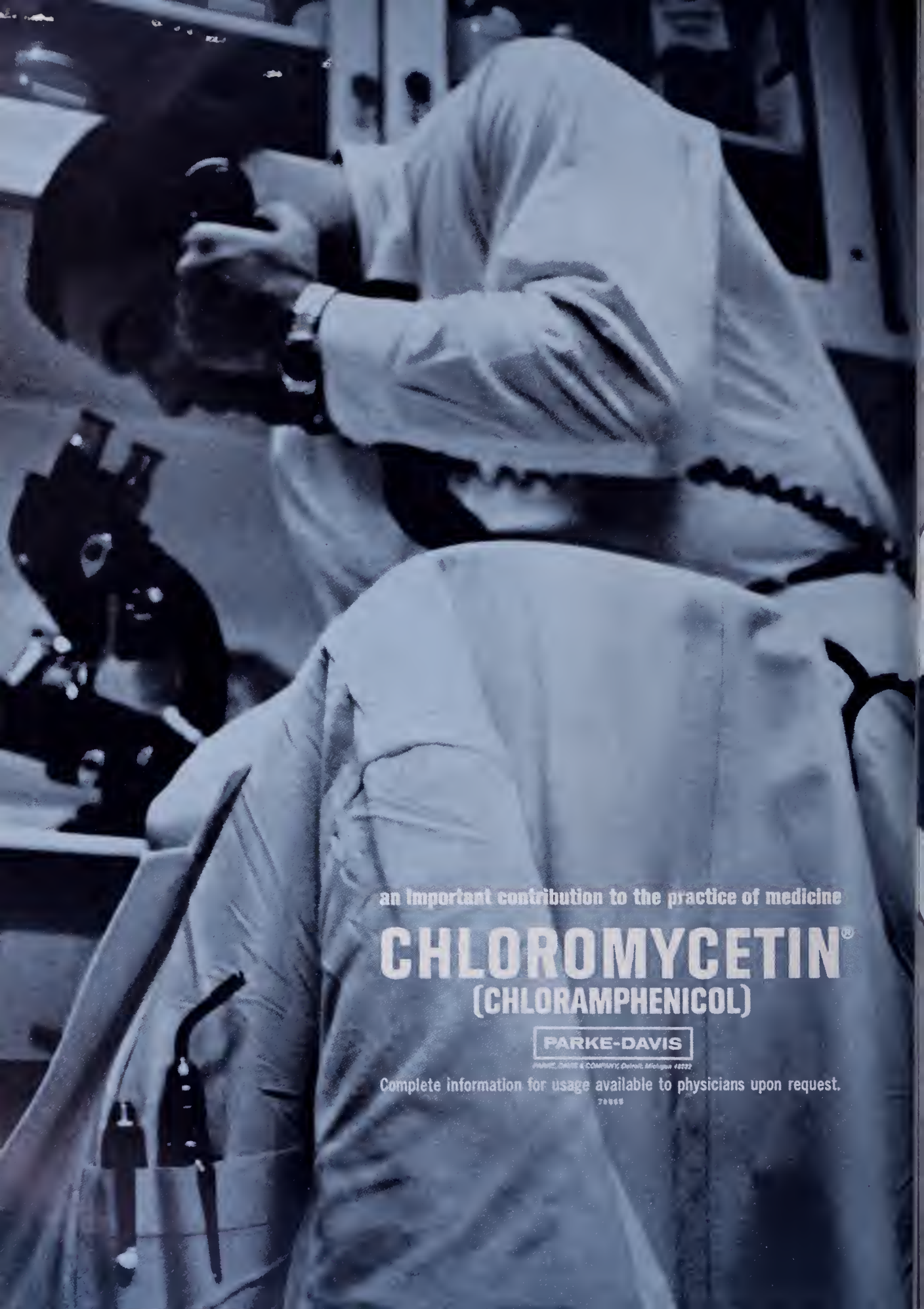
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MESSAGE FROM THE PRESIDENT



Swan Song

EVERY year, about this time, the President is preparing for the big event, the annual KMA meeting. He also begins to express his gratitude for the honor of having served his association as its leader. I, like my predecessors, am grateful for this honor, which is the greatest my colleagues can bestow. I shall cherish it, with its associated experiences, so long as I live.

However, my task is not completed. The annual convention is the event of the year. Many people have put in many hours in preparing the program for you this year. Expense has not been spared. The talent is of the best. The scientific portions should be unexcelled, both in the general and specialty group sessions. The telephone seminar should prove most interesting. Also, there will be 22 outstanding scientific exhibits.

As usual, our technical exhibitors will be present; this year a record number, with the latest drugs, instruments, appliances and equipment. These people are loyal to our profession; they are our friends and they bear the expense of our Annual Meeting. We are obligated to visit with them, hear their stories, and show our appreciation.

Each year, the President selects the speaker for the President's Luncheon. This year I have been most fortunate in being able to secure Dr. Philip M. Crane, a professor of history from Bradley University, as the speaker at noon, Wednesday, September 22. Doctor Crane is a dynamic young speaker who has a message you will want to hear. The title of his address will be "The American Dilemma".

This will be my last message to appear in The Journal. However, I will give the Presidential address on Tuesday morning, September 21. I have been given the dangerous privilege of selecting my own subject and saying what I please. The subject is "Medicine's Finest Hour". I believe what I have to say will be important and I hope that you will be present.

Delmar M. Edwards

Which Member of the Wedding will have Biliary Dysfunction?

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Patients approaching middle age, as well as pregnant women who complain of constipation, belching, and flatulence, with no evidence of organic disease may be suffering from functional disturbance of the biliary tract.

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Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Ambulatory patients should be advised that drowsiness may result. Continuous dosage over an extended period is contraindicated since codeine phosphate may cause addiction.

Each 5 ml. teaspoonful of Novahistine DH contains phenylephrine hydrochloride, 10 mg., chlorpheniramine maleate, 2 mg., codeine phosphate, 10 mg. (Warning: may be habit forming), chloroform (approx.), 13.5 mg., l-menthol, 1 mg., Alcohol 5%. Each 5 ml. of Novahistine Expectorant contains the above ingredients and, in addition, glyceryl guaiacolate, 100 mg.

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PUBLIC HEALTH PAGE

Laboratory Procedures for Syphilis Serology

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health, Commonwealth of Kentucky

THE diagnosis of syphilis, particularly in its latent stages, may present a perplexing problem to the clinician and he frequently finds it necessary to rely very heavily on the laboratory for assistance. The relatively simple and inexpensive nontreponemal antigen tests such as the VDRL have proven very valuable in syphilis case finding and in the presence of typical history and physical may provide sufficient laboratory information for confirmation of the diagnosis of syphilis. They do, however, measure the presence of reagin, a nonspecific antibody which may be elevated in other diseases such as tuberculosis, malaria, leprosy, and certain collagen diseases, thus producing an occasional positive reaction in the absence of syphilis. This so-called "biological false positive" problem requires further laboratory study utilizing one of the most specific treponemal antigen tests.

At the present time the Treponema Pallidum Immobilization Test (TPI) is considered the most sensitive and specific serologic test available for syphilis. This test, however, is a relatively expensive procedure (approximately $40 per test). It is a very complicated test to perform and is available from only a few reference laboratories. The TPI test may be obtained from a reference laboratory through the Division of Laboratory Services of the Kentucky State Department of Health, but it has been sugested, for the reasons mentioned above, that requests for this procedure be limited to those problem cases which cannot be resolved by the use of one of the other serologic tests for

The Division of Laboratory Services does, however, offer other treponemal antigen tests which may be of value in resolving biological false positive problems. The Reiter Protein Complement Fixation Test (RPCF) is a complement fixation test utilizing an antigen prepared from the non-pathogenic Reiter treponeme. Experience has shown that the RPCF, although a relatively specific test for syphilis, is somewhat lacking in sensitivity resulting in an occasional false negative test. Negative RPCF tests therefore should be followed by a more sensitive treponemal test.

The Fluorescent Treponemal Antibody-200 (FTA-200) has been evaluated by the Fluorescent Antibody Unit of the Division of Laboratory Services and the laboratory is now ready to perform this procedure by special request where the question of a biological false positive exists. The FTA-200 is very high in specificity and it has much greater sensitivity than the RPCF, although not as sensitive as the TPI. Compared with the TPI it is relatively simple and inexpensive to perform. A modification of the FTA-200 is presently under investigation and experimental results indicate that the new procedure may equal the TPI test in sensitivity and specificity.

It is suggested that all reactive VDRL tests be followed by either the RPCF or the FTA-200 unless a diagnosis of syphilis based on history and physical can be made. If either RPCF or FTA-200 are nonreactive or if the question of a biological false positive still exists, a TPI test should be requested. The RPCF or FTA-200 may be requested from the Division of Laboratory Services by submitting at least 5 ml. of clotted blood in the regular syphilis serology mailing container. Specimens for TPI must be aseptically collected and submitted in a special container which may be obtained from the Division of Laboratory Services. All of these tests are available without charge.

† *This article was prepared by B. F. Brown, M.D., M.P.H., Director, Division of Laboratory Services, Kentucky State Department of Health, 275 East Main Street, Frankfort, Kentucky.*



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IN THE BOOKS

A SYNOPSIS OF CONTEMPORARY PSYCHIATRY, Third Edition: by George A. Ulett, M.D., and D. Wells Goodrich, M.D.; Published by the C. V. Mosby Company, St. Louis, 1965; 299 Pages; Price, $6.75.

A reviewer or prospective buyer can usually tell much about the contents of a book by its title. This one, for instance, tells us it is a synopsis (or an abstract) and is also contemporary (revised editions may be expected each year). It is one of a series published by Mosby considering the different specialties of medicine.

Essentially this small volume is a condensed textbook of psychiatry. The authors have blueprinted this large field by paring away all but the most cogent material. The remaining distillate is a vital, well planned and qualitatively good fragment.

For a reader to derive value from a synopsis presupposes a substantial background of knowledge already present since the book can serve only to organize infromation or to refresh one's memory. But a summation is all too brief for the neophyte since some depth of understanding is necessary to make reading worthwhile. The discerning reader will find much greater satisfaction in one of the standard psychiatric texts which will provide the whole body of material rather than the bare skeleton.

HOMER B. MARTIN, M.D.

OBSTETRICS (DeLee); 13th Edition: by J. P. Greenhill, M.D.; Published by W. B. Saunders Co., Philadelphia and London, 1965; 1246 Pages; Price, $20.00.

This is the 13th edition of the textbook *Obstetrics* which was the original text of Joseph B. DeLee, M.D. The original DeLee edition appeared a little more than fifty years ago. Doctor Greenhill and his collaborators have written the last six editions of this book.

The book is a large and complete work in which 32 contributors who are outstanding authorities in their particular areas have put forth their knowledge in current up-to-date fashion. The work has extensive sections on the physiology of reproduction and the biochemistry of pregnancy. There are extensive essays on complications of pregnancy and medical diseases complicating pregnancy. These are extremely well covered.

The words "complete, up-to-date, and well-written" characterize this very fine book which makes an excellent text for students and also those who practice clinical obstetrics. Likewise, there is valuable material for the researcher in this area of medicine.

JOHN W. GREENE, JR., M.D.

FROM AUSCULTATION TO PHONOCARDIOGRAPHY: by Aldo A. Luisada, M.D.; Published by W. B. Saunders Company, Philadelphia, 1965; 314 Pages; Price, $17.75.

For the past 25 years Doctor Aldo A. Luisada has been one of the leaders in the field of phonocardiography, a discipline which, to quote the author, "is so connected with physical examination on the one hand and with technical problems on the other hand that it may be practiced according to different viewpoints and with different results."

In the introduction the author states several reasons why phonocardiography is superior to auscultation. In the text he proves these arguments convincingly. The book consists of 35 relatively short chapters which offer a succinct and comprehensive review of a given subject. Although certain overlapping of subjects is unavoidable, the amount of repetition is kept at a minimum. Some of the best chapters include the sections on technical aspects. The clarity of the presentation of the physical concepts will be appreciated by a physician who has become rusty in the field of physics and electronics. Another outstanding chapter is devoted to functional and innocent murmurs, an area of some of the greatest misinterpretations in clinical practice.

The reader will find certain new views somewhat "revolutionary," particularly the new concept of the origin of the first sound and the re-naming of the areas of auscultation. Although these new views are based on the sound experimental work conducted largely by the author and his co-workers, one must point out that not all of these views have yet been universally accepted.

As usual in the case of an investigator who has made many research contributions of his own, the personal investigations receive the greatest emphasis in the book. However, the studies and points of view of other investigators are quoted rather adequately. It is obvious that a book of this size cannot cover all details of phonocardiographic diagnosis. By necessity, certain subjects such as assessment of severity of pulmonary stenosis or of Tetralogy of Fallot or the subject of venous hum are touched upon only very lightly. However, the wealth of material contained in the book makes it highly valuable as a source of information and references for all practitioners, particularly the internists and cardiologists interested in phonocardiography and auscultation. The bibliography is adequate. The illustrations are of good quality. The format and print make the book convenient to use and pleasing to read.

BORYS SURAWICZ, M.D.

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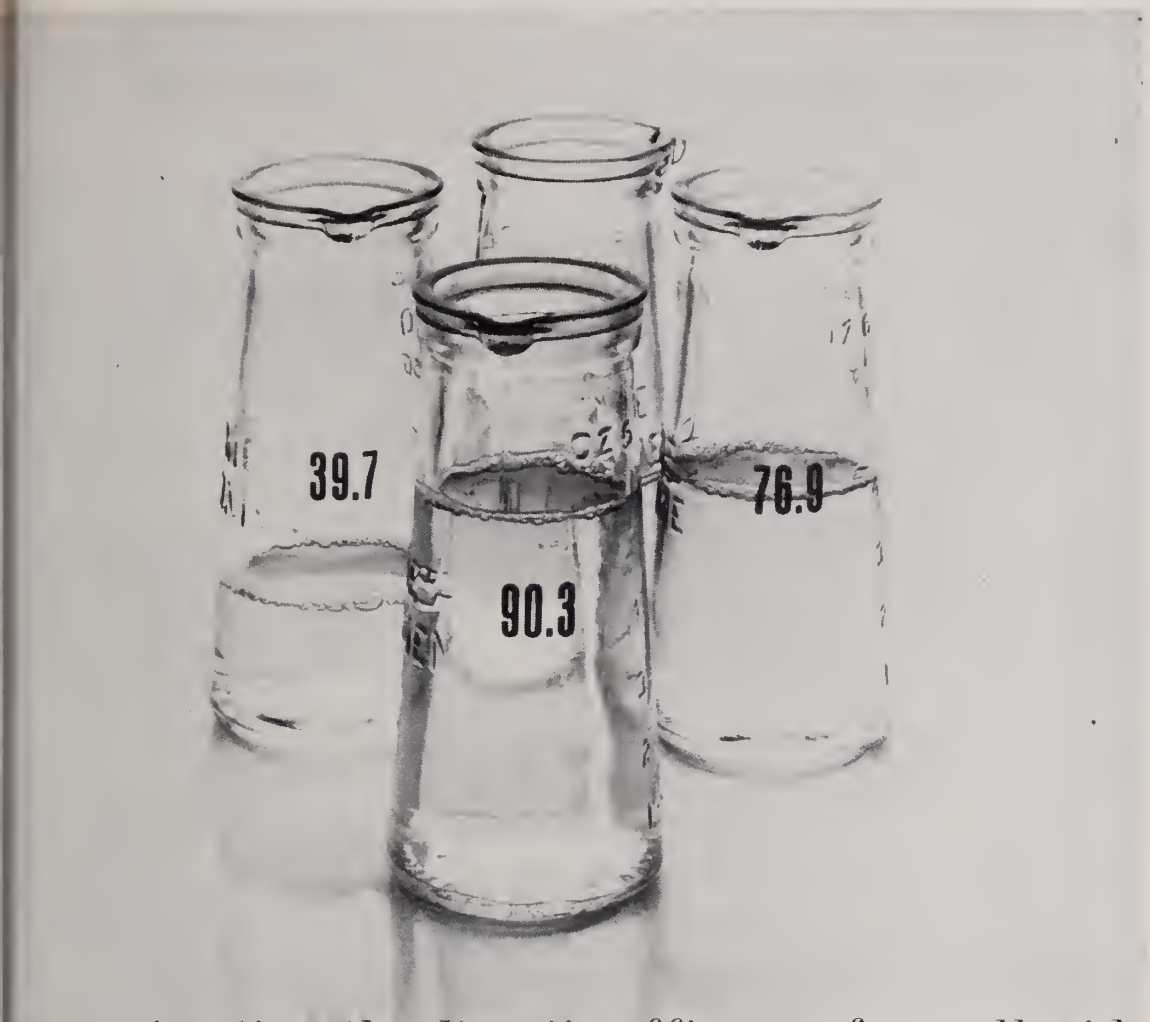
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*)ld, H., *et al*: Closed Panel Conference: Present Status of the nagement of Congestive Failure and Advances in Diuretic erapy, Journal of New Drugs, 1:177, July-August, 1961.

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IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

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IN BRIEF:

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

Contraindications and Precautions: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established.

Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

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7 KAGP Maysville Seminar, Mason County Health Department, Maysville

13 Postgraduate Course in Anesthesiology, University of Louisville Medical Center

21 KAGP Symposium on Industrial Medicine, Stouffer's Louisville Inn, Louisville

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15-19 Postgraduate Course #7, American College of Physicians, Pathophysiological Basis of Therapeutics, University of Kentucky Medical Center, Lexington

DECEMBER

16 Norton Memorial Infirmary Annual Postgraduate Seminar, on Medical and Surgical Diagnosis, Norton Infirmary, Louisville

IN SURROUNDING STATES

SEPTEMBER

14-17 American Association of Blood Banks, Americana Hotel, Bal Harbour, Florida

16-18 International Cardiovascular Society (7th Congress), Bellevue-Stratford Hotel, Philadelphia

17-19 American Academy of Pediatrics (Pennsylvania State Chapter), Bedford Springs Hotel, Bedford, Pennsylvania

19-24 Michigan State Medical Society (Centennial Session), Sheraton-Cadillac Hotel, Detroit

21-24 Pennsylvania Medical Society, Chalfonte-Haddon Hall, Atlantic City, New Jersey

24-25 Symposium on Pulmonary Disease, Ohio State University College of Medicine, Columbus O.

27-28 Tennessee Valley Medical Assembly, Tivoli Theater, Chattanooga

29-30 Postgraduate Course on Recent Advances in Clinical Pathology, Cleveland Clinic, Cleveland, O.

OCTOBER

6-7 Postgraduate Course on Gastroenterology, Cleveland Clinic, Cleveland, O.

7-8 Central Association of OB-GYN, Netherland Plaza Hotel, Cincinnati

7-9 American College of Physicians Fall Meeting, Deauville Hotel, Miami Beach, Fla.

10-13 Medical Society of Virginia, John Marshall Hotel, Richmond

11-13 Academy of Psychosomatic Medicine, Sherman House, Chicago

11-14 Second Postgraduate Course on Fractures and other Injuries, Riviera Motel, Atlanta, Georgia

12-14 Indiana State Medical Association, Murat Temple, Indianapolis

13-14 Postgraduate Course on Hematology, Cleveland Clinic, Cleveland, O.

15-19 American Heart Association, Americana Hotel, Bal Harbour, Florida

18-22 American College of Surgeons Annual Clinical Congress, Dennis Hotel, Atlantic City, New Jersey

23-28 American Academy of Pediatrics, Palmer House, Chicago

29-30 Symposium on Common Problems in General Practice-Office Procedures, Mound Park Hospital Foundation, Florida

Academy of General Practice, 16th Annual Scientific Session, St. Petersburg

30-31 Disaster Medical Care, 16th National Conference, Drake Hotel, Chicago

NOVEMBER

5 International College of Surgeons, State Division, Urbana, Ill.

8-11 Western Hemisphere Nutrition Congress (AMA Council on Food and Nutrition), Edgewater Beach Hotel, Chicago

11-13 Inaugural Scientific Program of new Ancker Hospital, St. Paul, Minn.

17-20 American Academy of Orthopedic Surgeons, Postgraduate Course on Treatment of Injuries, Marriott Motor Hotel, Dallas

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QUESTION: How is the accident x-ray allowance determined in Schedules "C" and "D"?

ANSWER: *All allowances in Schedules "C" and "D" were established by applying a conversion factor to the listed unit values in the Professional Service Index. There is an indemnity allowance (Endorsement IV-A) provided for the initial x-rays (not re-rays) following an accident of each injured part of the body, provided the x-ray is taken within 30 days of the accident.*

QUESTION: How does Blue Shield determine its allowances on lacerations?

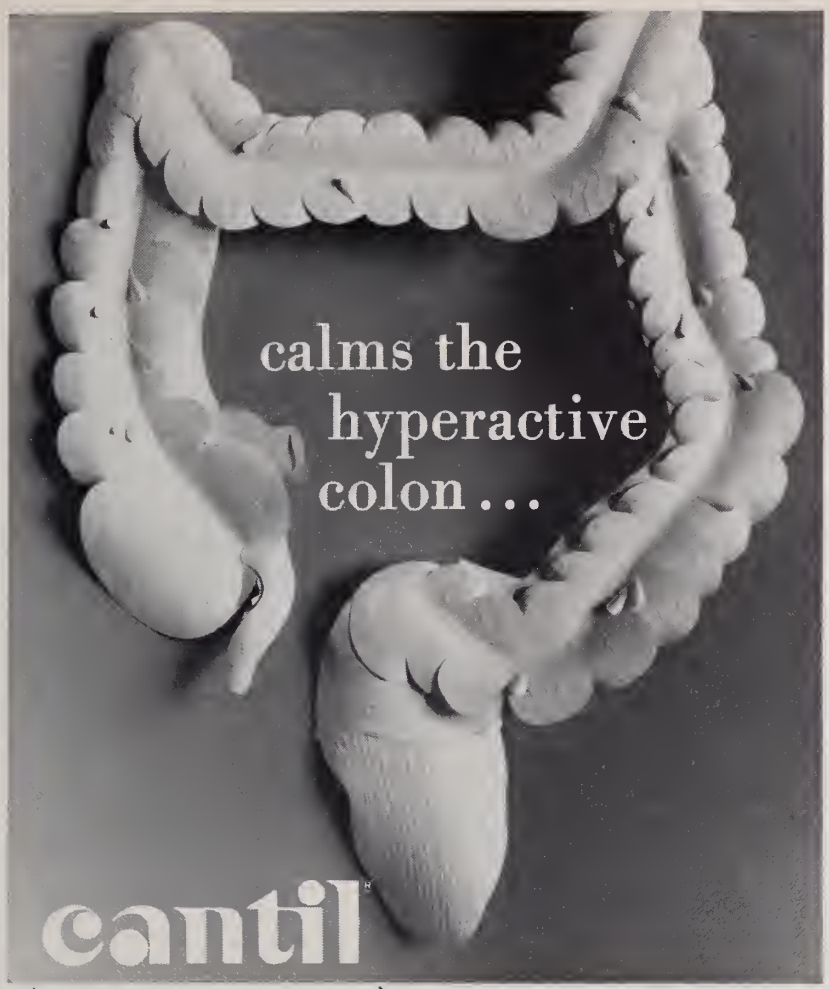
ANSWER: *These are determined according to the instructions on page three of the C & D Manual. 1. Number of lacerations. 2. Location on body. 3. Length and depth of lacerations. The indemnity allowances differ according to the type Blue Shield contract for which the member is paying.*

QUESTION: Why are there often variations between Blue Shield allowances and charges for services by physicians?

ANSWER: *Most Blue Shield Schedules are indemnity allowances, however, they represent only an allowance toward the physician's fee for the services, and do not attempt to fix the value of the services.*

QUESTION: I'm going to California on a visit. If I should have an accident or need my Blue Shield protection out there, how is the claim handled?

ANSWER: *The subscriber furnishes his physician with his certificate and group number, and the name and address of the Blue Shield Plan where membership is held. He should instruct the physician to file a claim describing the services and charges. The physician may use the local Blue Shield Claim Form for that state. In accident cases, the subscriber should furnish his physician with the nature, place and date of the accident, which should be enclosed with the information on the claim form.*



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IN BRIEF:

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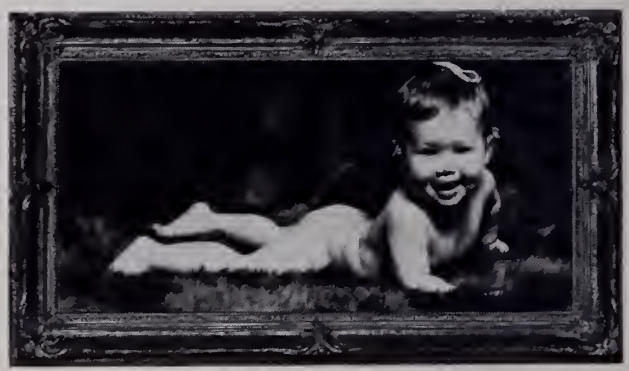
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1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957
2—Asher, L.M.: Am. J. Digestive Diseases *4*:272 (Apr.) 1959

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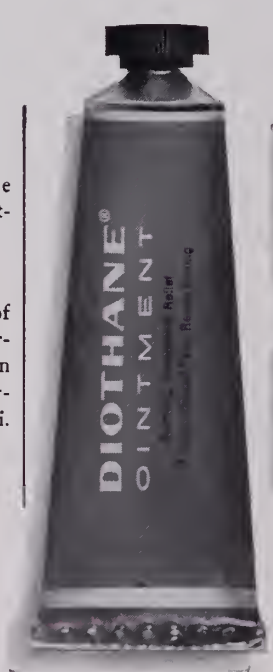
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References: 1. Goldsmith, J. W.: Minn. Med. (Feb.) 1957. 2. Groskloss, H. H., Clancy, C. L., Healey, E. F., McCann, W. J., Maloney, F. D., Loritz, A. F.: Clinical Medicine (Sept.) 1955. 3. Codling, J. W., Lowden, R. J.: Northwest Med. (March) 1958. 4. Bethea, R. C.: International Record of Med. (May) 1960. 5. Lenz, W., Second International Conference on Congenital Malformations, N. Y., N. Y., (July) 1963.

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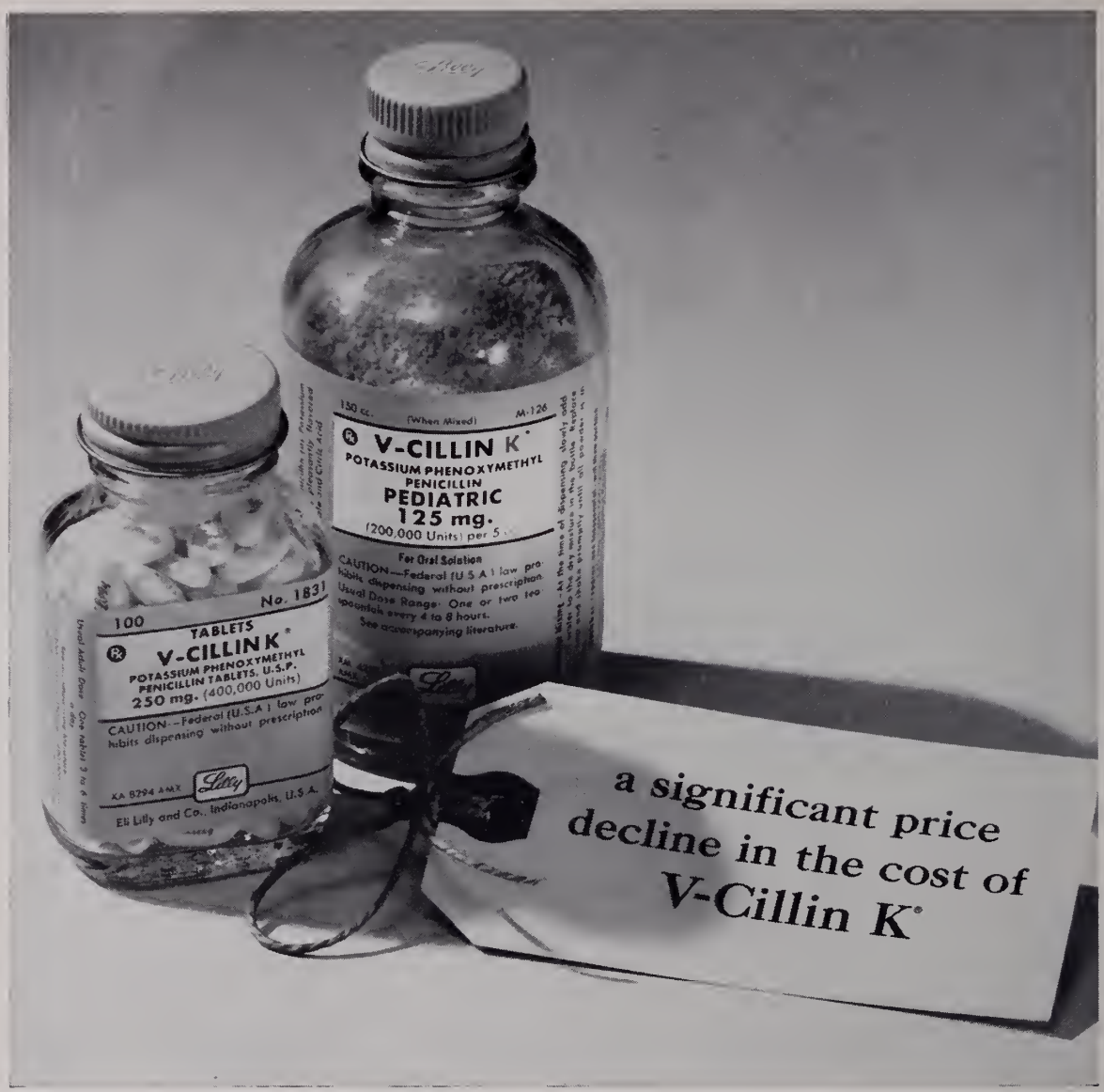
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Syphilis and Seroreactivity as Seen in Private Practice†

Harold J. Schupbach, M.D.
Owensboro, Ky.

Though syphilis is increasing, few physicians encounter early syphilis. Later manifestations are prevalent but easily overlooked unless one maintains awareness of the disease and makes broad use of the routine serology.

UNTIL the end of the Second World War the variety and wide prevalence of syphilis was commonly recognized. Syphilis as the great imitator of morbid states was uppermost in the minds of physicians. Clinics and wards were devoted to the care and treatment of this single ailment, and the syphilologist was one of the first medical specialists.

The application of effective public health venereal disease control and inexpensive antibiotic therapy resulted in a marked decrease in incidence of syphilis, and a subtle change in the patterns of morbidity has been noted. As this has occurred, a new generation of practitioners has matured. The individual physician of this generation remembers syphilis as an acute disease encountered in soldiers or as dimly recollected from student days as a clerk in V.D. clinics. In his practice he has seen syphilis only sporadically. The darkfield microscope is a forgotten tool and to obtain a darkfield examination is at times difficult. The routine admission "serology" is no longer standard procedure, and five states require no premarital serologic test, while eight do not require prenatal serology.[1]

The effect upon medical practice of the foregoing has been a declining index of clinical suspicion for, and a neglect of, syphilis which may well lead to a tragic increase in the late disabling manifestations of this otherwise easily curable and preventable malady.

Numerous reports testify to the widespread resurgence of primary syphilis and delineate the changing patterns of morbidity and epidemiology, especially as pertains to teen-agers and homosexuals.[2]

Despite the well-established evidence for the recrudescence of primary syphilis, it is my belief that the concern of the private practitioner should *especially* be directed to the later manifestations of syphilis, for this is more commonly what he will see. Why should this be so? First, primary syphilis is seldom overlooked when seen as a characteristic chancre. The pitfalls here are inadequate therapy and failure to conduct contact investigation and follow-up. All of these pitfalls can be easily avoided by attention to details of treatment and the enlistment of the readily available public health epidemiological assistance.

Secondly, primary syphilis is much less frequently encountered in private practice than later manifestations. Forty to sixty percent of

† *Presented at the September 30 meeting of the Kentucky Chapter of the American College of Physicians during the 1964 Annual Meeting of the Kentucky Medical Association.*

patients with primary and secondary syphilis ignore the signs and symptoms of their disease.[3] Kampmeier, discussing the paucity of teaching material, says, "Infectious syphilis has disappeared from many universtiy hospitals."[4] For probably somewhat the same reasons, infectious syphilis has to a large extent disappeared from the private physician's office. In support of this view, Brown says, "Many physicians are probably still correct when they say they haven't seen a case of early syphilis in 20 years. A few physicians are seeing a considerable number of cases; the bulk of these cases are sparsely scattered."[5] If the annual incidence of acute syphilis is 60,000 cases[4] and two thirds of these saw a private physician, and if all were evenly distributed, slightly less than one in four of us might expect to see an instances of primary syphilis annually. But many factors are at play to distort the picture. Some of these are the predominance of the disease among teen-agers and young adults, homosexuals, low-level socio-economic groups, prostitutes, soldiers, sailors, etc. Therefore, the cases of primary or acute infectious syphilis are increasingly likely to be encountered in veneral disease clinics, jails, military clinics, and by practitioners serving patient populations in the 15-25 year age group or by urologists and dermatologists, and especially by those practicing in larger urban areas. Do not misunderstand this point. Primary syphilis should not be ignored, and each one of us must think of it especially in genital, mucous membrane, and skin disorders. On the other hand, for each instance of primary syphilis, there lurk hidden from view many more cases of latent or systemic syphilis in the practice of each of us. It is to emphasize this point, and to call attention to the protean character of syphilis, to call again to your mind the value of the routine serology in diagnosis, and to stress the frequent occurrence of syphilis that the following material is presented. It consists of an analysis of all instances of syphilis and seroreactivity seen in the author's private practice of internal medicine during the ten-year period 1954-1964. The community represented is an approximately equally mixed urban-rural area of 100,000, and the total patient population from which the cases were drawn is estimated to be 10,000, predominantly adult or elderly individuals. In all, 31 cases were encountered. Seventeen were instances of active clinical syphilis, eight others had been adequately treated but required evaluation to determine this fact, and the remaining six were instances of biologic false positive reactors.

The absence in this series of a single instance of primary syphilis was puzzling at first, though some of the reasons for this have been mentioned. To test the validity of this experience, 41 of the 60 practitioners in Owensboro were surveyed and only two recalled having seen primary syphilis in the period 1956 to the present. Furthermore, a review of 111,025 hospital admissions to the Owensboro-Daviess County Hospital from 1954 to 1964 disclosed 69 diagnoses of syphilis, but none were primary.

To challenge your imagination and, hopefully, to arouse your curiosity for this sadly neglected disease, three cases will be described briefly and a more detailed analysis of the entire series will follow.

Case Presentations

Case 6. A 54 year old white female complained of weakness suggesting hypoglycemia and on physical examination a right abdominal mass was discovered. Exhaustive studies did not definitely disclose its nature and exploratory laparotomy was done. At surgery, a liver deformed by the typical fibrotic strands of hepar lobatum was immediately apparent and led to the postoperative determination of the serology which was positive in 32 dilutions. She had no history of syphilis nor did her husband, but when he was examined he was found to be tabetic (Case 7). Though the surgical approach to the diagnosis of lues is cumbersome to say the least, the appreciation of the hepatic manifestations of the disease led to its successful treatment.

Case 9. A 66 year old schoolteacher was referred by an insurance company for a disability retirement examination. Two years earlier, he had had transient right hemiparesis lasting three days. For 12 months, he had experienced headaches, scintillations of vision, transient diplopia, and aphasia. Angina pectoris had been present for six months. He denied syphilis. Arteriosclerosis was the only finding on physical examination. A routine VDRL was twice positive in four dilutions. A spinal fluid examination was done and the VDRL was reactive; the cell count was 22 lymphocytes. A diagnosis of meningovascular

syphilis was made and 12 million units of penicillin given. In four years of observation he has remained well, all symptoms have subsided, and retirement has been unnecessary. Without a serology, this would reasonably have been considered an instance of arteriosclerotic cerebrovascular insufficiency.

Case 17. Here is another example of the surgical diagnosis of syphilis that could probably have been circumvented by a routine serology. A 48 year old man with a five- to six-year ulcer history, had by x-ray a greater curvature gastric ulcer. Because of achlorhydria and x-ray appearance, malignancy was considered likely and gastrectomy was performed. The pathologist reported a diffusely thickened, fibrotic stomach infiltrated by lymphocytes. Could this be syphilis? A serology was obtained and was positive in 4 dilutions. Spinal fluid serology was negative, but the gold curve was 0112210000. There seems little doubt that this was an instance of late gastric syphilis. Appropriate treatment was given.

Active Clinical Syphilis

A review of 17 cases of syphilis considered to represent active disease requiring antibiotic therapy discloses a number of interesting features (Table 1).

Seven patients presented themselves with chief complaints which ultimately proved to be attributable to luetic disease. In four, this was immediately apparent either from characteristic symptoms or physical findings and included three patients with tabes dorsalis and one with pain of an aortic aneurysm. The other three required more elaborate study before the true nature of their ailment was established, and these included one with hypoglyemic weakness due to hepatic syphilis, one with ulcer-like symptoms due to gastric syphilis, and one with nervous system symptoms due to meningovascular syphilis. In addition, there were three in whom the diagnosis was also suspected from secondary complaints uncovered in the course of routine systems review conducted on the initial examination. Thus, a total of ten cases, or 58%, were found to have syphilis as a result of investigation of complaints presented at the time of their initial examination. Of these, five had no history of syphilis. Two other patients had a history of syphilis but were without complaints attributable to it. Investigation of the status of treatment established the need for further therapy despite the lack of symptoms or physical findings of syphilis.

On the other hand, the value of the serologic test for syphilis was amply demonstrated by the fact that in ten of the 17 cases the correct diagnosis either would not have been suspected or could not have been established without it. The result of the serology led to the

TABLE 1
Active Syphilis Infections

Case	Age	Sex	Race	Previous Syphilis	Diagnosis by*	Spinal Fluid	Reason for First Visit	Luetic Diagnosis
1	55	M	W	No	S	—	Bronchitis	Syphilitic aortitis
2	37	F	N	Yes	S	Pos.	Check-up	Asymptomatic neuro.
3	52	M	W	?	HPS	—	Constipation	Tabes Dorsalis
4	67	M	W	No	S	Neg.	Check-up	Late latent
5	35	M	W	Yes	HS	Pos.	Check-up	Asymptomatic neuro.
6	54	F	W	No	S	—	Hypoglycemia	Hepar lobatum
7	56	M	W	No	PS	Pos.	Wife's illness	Tabes dorsalis
8	37	F	W	No	S	Neg.	P.I.D.	Early latent
9	66	M	W	No	S	Pos.	Disability exam	Meningovascular
10	57	F	W	No	S	Neg.	Check-up	Late latent
11	51	M	W	Yes	HPS	Pos..	Symptoms of tabes	Tabes dorsalis
12	73	F	W	Yes	HP	—	Aneurysmal pain	Syphilitic aortitis
13	54	M	W	Yes	S	—	Prostatitis	Late latent
14	58	M	W	?	HPS	Pos.	Influenza	Tabes dorsalis
15	76	M	W	Yes	S	Neg.	Asthmatic bronchitis	Late latent
16	48	M	W	Yes	HP	—	Tabes & G.U. infection	Tabes dorsalis
17	48	M	W	Yes	S	Neg.	Ulcer pain	Late gastric

*S—Serology H—History P—Physical Exam

correct interpretation of a puzzling clinical syndrome in three instances and uncovered unsuspected syphilis in seven others. Of these ten, only three had a prior history of syphilis. This history was obtained in retrospect after the result of the serology was known in two of these cases. The serology was performed as a routine procedure comprising part of the initial examination in 13 cases.

The diagnosis of syphilis was readily apparent from history and/or physical findings in the other seven patients in the series, and of these the serology was positive in five. The remaining two had a history of syphilis with inadequate treatment and clinical disease that warranted retreatment with penicillin. All seven admitted past syphilis on initial interview.

In 14 cases, the discovery of syphilis resulted in either arrest of progression or improvement as a result of treatment, and of these, seven are believed to have been restored to normal health. Two refused treatment and follow-up. Both had late noninfectious disease. The third untreated patient died of rupture of her aortic aneurysm before studies were completed and may have represented the late sequela of burned-out disease, though her past therapy was judged inadequate by current standards.

Detailed results of contact studies are not available. Suffice it to say that one instance of active conjugal syphilis and one of adequately treated syphilis were uncovered. In four others, syphilis was not found in the marital partner. Four had no sexual partner, and four were returned to their referring physicians for contact evaluation. Only two cases (2 and 8) were considered to be in a possibly contagious state. The first of these was four months pregnant when the diagnosis was established, and with treatment, a healthy seronegative baby was delivered.

Inactive Syphilis

There were eight patients who represented instances of adequately treated syphilis (Table 2). Study was necessary in each instance to ascertain the status of their disease and to establish the adequacy of treatment. Two were seen because of symptoms due to syphilis—one with tabetic pain and a negative serology, the other with luetic heart disease, also seronegative. Both had had previously positive serologies and records of adequate treatment were obtained. A third case also had late symptomatic neurosyphilis with Argyll-Robertson pupils, Meniere's syndrome, and VDRL reactive to 2 dilutions, but the spinal fluid was normal and a history of satisfactory treatment was obtained.

The remaining five had merely persistent low titer seropositivity (maximum 2 dilutions). One of these was discovered on premarital examination, two as a result of routine serology and history, and the remaining one by routine serology in the course of a routine physical examination. All five had a history of previous syphilis; and, again, from their examination and treatment records, further treatment was considered unnecessary.

Biologic False Positive Cases

There were six cases (Table 3) considered to have biologic false positive reactions (B.F.P.). Two occurred in men and four in women. Titers varied from weakly reactive to 4 dilutions. None had a history of syphilis. Of the males, one had erythema multiforme; a

TABLE 2
Adequately Treated Syphilis*

Case	Age	Sex	Serology	Spinal Fluid	Reason for First Visit	Luetic Diagnosis
1	47	F	Neg.	Neg.	Lightning pain	Tabes dorsalis
2	32	F	1:2	0	Check-up	Serofast
3	44	F	1:1	Neg.	Cosmetology certificate	Serofast
4	46	F	1:2	Neg.	Check-up	Symptomatic neurosyphilis
5	52	M	1:1	0	Premarital	Serofast
6	77	F	Neg.	0	Cardiac consultation	Cardiovascular
7	55	F	1:1	0	Hypertension	Serofast
8	67	M	1:1	Neg.	Cholangitis	Serofast

*All patients were white and all had a previous diagnosis of syphilis.

TABLE 3
Biologic False Positive Reactors*

Case	Age	Sex	VDRL	Follow-up VDRL	RPCF	TPI	Spinal	Other	Diagnosis
1	28	F	1:1	Neg.	0	0	0	Heterophile 1:56	Glandular Fever
2	19	F	1:2	Neg.	0	0	0	Neg. L.E.	Probable L.E.
3	26	M	1:4	—	4+ neg. neg.	0	0	—	Erythema multiforme
4	30	M	1:1	1:1	0	Neg.	Neg.	—	No disease
5	44	F	1:1	Neg.	Neg.	0	Neg.	Neg. L.E. 4+ ceph. floc.	Possible L.E.
6	51	F	1:2	—	Neg.	Neg.	—	—	Parkinson's syndrome

*All patients were white; none had a previous history of syphilis.

routine VDRL was weakly reactive. A 4+ Reiter Protein Complement Fixation (RPCF) was seen during the acute illness, but one month later, two RPCF determinations in different laboratories were negative. This case should be followed, and if a persistently positive VDRL is encountered, a Treponema Pallidum Immobilization Test (TPI) should be done. The other male had a persistently positive VDRL weakly reactive to one dilution, a negative spinal fluid, and a negative TPI.

One woman had an acute glandular fever with palatine petechiae, a heterophile of 1:56, and a weakly reactive VDRL which became negative on subsequent observation. Another presented a lupus erythematosus-like syndrome and negative L.E. test. Again, serology became negative with observation. The third had a transiently reactive VDRL, negative RPCF, and a 4+ cephalin flocculation but has otherwise been well. The fourth was found to have a positive serology in the course of study of Parkinson's syndrome. A Reiter Complement Fixation Test and TPI were negative.

The evaluation of the low titer VDRL in the absence of history or physical findings is a vexing problem. In Fiumara's experience, 80 percent of patients with reactive blood tests without detectable lesions of syphilis will prove to have syphilis.[6] The repetition of the VDRL slide test and, if positive, the successive testing with RPCF and TPI according to the routine described by Carpenter et al.[7] and by Fiumara[6] provides an effective means to differentiate the biologic false positive reactor from the latent syphilitic patient. If the RPCF and/or the spinal fluid serology is positive, syphilis may be diagnosed; if negative, the TPI should be resorted to and even if weakly reactive, a diagnosis of syphilis is required. A common error is to regard a negative RPCF as evidence that syphilis is absent, whereas its only value is in a positive test providing confirmatory evidence of syphilis. A negative result demands resort to a negative TPI test to exclude syphilis.

Summary and Conclusions

An analysis of 31 patients with reactive serologic tests for syphilis seen during the past decade confirms once again the continued prevalence of syphilis in private practice. Its tendency to masquerade as other ailments or to lurk in latent form is apparent. The value of the often neglected routine serology is emphasized. The evaluation of the previously treated patient and the biologic false positive reactor is briefly discussed.

Syphilis is common.
Its cause is known.
Its epidemiological behavior is well understood.
Its pathogenesis is well documented.
Its treatment is both effective and inexpensive.

Despite all this, it remains one of the major contagious disease problems. Fracastorius has yet to be discredited when he said:

"This plague should never be estinguisht here
Since then your Soil must ne'er be wholly free,
Beg Heav'n at least to yield some Remedy."[8]

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(Continued on Page 726)

Resection of An Extracranial Aneurysm of the Internal Carotid Artery

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An extracranial internal carotid artery aneurysm was resected using an internal shunt to maintain cerebral flow and serve as a stent to prevent compromise of the arterial lumen during repair with a patch graft.

ANEURYSM of the extracranial portion of the internal carotid artery is unusual, but case reports of its surgical treatment are now appearing. Most often, cerebral flow has been restored after resection of the aneurysm by arterial graft or by anastomosis of the distal internal carotid to the external carotid artery. This report concerns a case successfully treated in 1962 by patch graft angioplasty after resection of the aneurysm left part of the wall of the carotid intact.

Case Report: Mrs. E.C., a 63-year-old white female, was admitted to hospital with a slowly-expanding cervical mass, which had been present for about three months and was located behind the anterior border of the upper third of the left sternomastoid muscle. At first, this was considered to be an enlarged lymph node or branchial cleft cyst until pulsation was detected in the lesion and a diagnosis of carotid body tumor was entertained. On February 10, 1962, under general anesthesia, a careful search of the pharynx and larynx ruled out a primary neoplasm in these areas. An oblique incision was then made over the tumor and a benign superficial lymph node excised. Deep to this, the mass was palpable in the region of the carotid bifurcation. After mobilization of the common carotid artery, it was determined that this was in reality an extremely thin-walled aneurysm of the internal carotid artery, about 3.5 cm. in diameter. Although the external carotid was adherent to the surface of the aneurysm, occlusion of this vessel did not affect the pulsation of the mass: when the internal carotid was clamped at its origin, the pulsation ceased. Dissection of the distal end of the aneurysm revealed an apparently normal internal carotid artery for about 1.5 cm. proximal to the base of the skull. The incision was closed so that the operative findings could be discussed with the patient and her relatives.

On February 11, the operative incision was reopened. Control was obtained of the common carotid artery, the external carotid artery above the mass, and the internal carotid artery at the base of the skull. Encircling ligatures were placed around the branches of the external carotid artery and the hypoglossal nerve was dissected from the distal end of the aneurysm (Figure 1).

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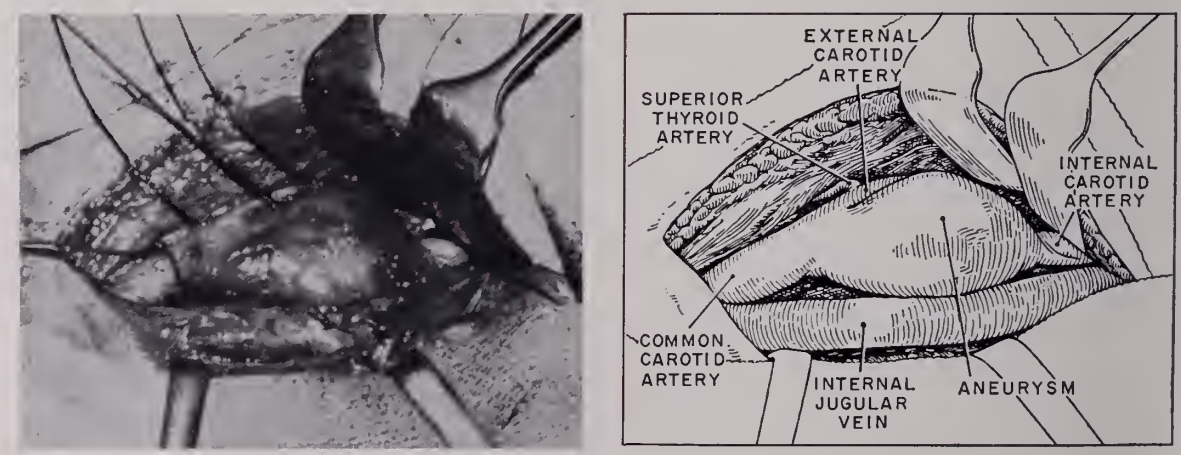


FIGURE 1. The aneurysm exposed.

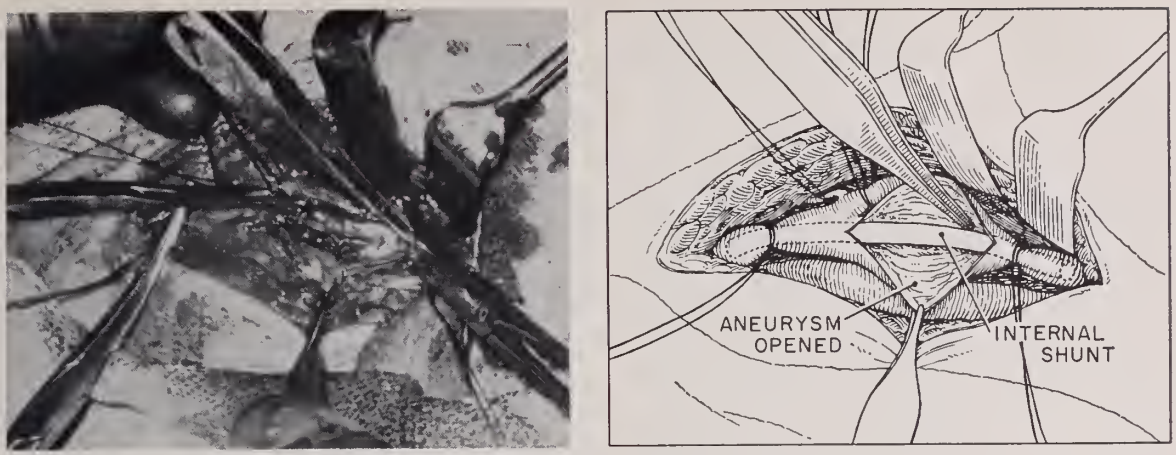


FIGURE 2. The aneurysm open with internal shunt in place.

After the intravenous injection of 25 mg. of heparin, the common, external, and internal carotid vessels were occluded with vascular clamps. The aneurysm was incised on its lateral aspect and the laminated clot within was removed so that the points of entrance and exit of the internal carotid artery could be found. A defect 1.5 cm. long in the anterior and lateral walls of the vessel was found, the posterior portion of the wall at this site being intact. An internal polyethylene by-pass shunt was inserted from the common to the internal carotid artery and cerebral flow established through the shunt after 90 seconds of occlusion (Figure 2).

Most of the aneurysmal sac was resected except for part of the medial wall, which was adherent to underlying structures. The defect in the artery was repaired with an elliptical Dacron patch graft (Figure 3). The internal shunt, which also acted as a stent to prevent compromise of the arterial lumen, was removed just before completion of the arteriotomy closure, and the proximal and distal carotid vessels were flushed. The closure was completed, the vascular clamps were removed, and a strong pulsation was noted in the internal carotid at the base of the skull.

On microscopic examination, the pathological specimen showed severe atherosclerosis with recent thrombosis as well as periarterial inflammatory infiltration with leukocytes. An internal elastic membrane was present in the wall of the aneurysm.

The patient's postoperative recovery was uneventful, no major neurological deficit being present and the incision healing primarily. She did have some hoarseness for three days and partial weakness of the left hypoglossal nerve function for three weeks. Re-examination in six months and at two years showed no recurrence of the lesion, no neurological symptoms, a strong pulsation in the carotid vessel, no bruit over the area, and a good superficial temporal pulse.

Summary

An aneurysm of the extracranial part of the internal carotid artery was successfully resected, an internal shunt being used to maintain cerebral blood flow. Part of the posterior wall of the vessel at this site appeared normal and was left intact. The resulting defect was closed with an elliptical Dacron patch graft, the internal shunt serving as a stent to prevent compromise of the arterial lumen during the repair.

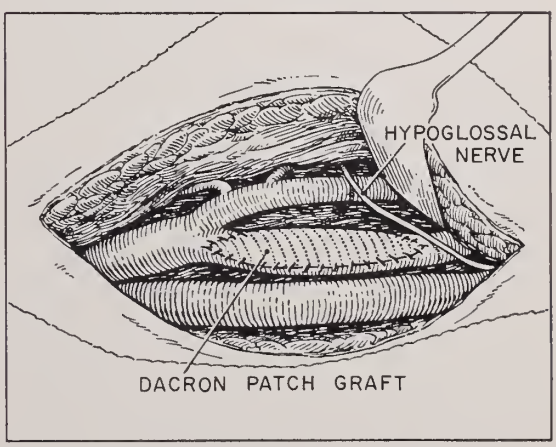


FIGURE 3. The completed repair.

Post-Graduate Training for Non-Psychiatric Physicians†

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The rationale for, and the inherent difficulties of postgraduate teaching of psychiatry are presented. A course presently being offered is described and results and plans for the future are discussed. The need for effective evaluation of such a course is stressed.

THE revolution in medical technology, medical science and medical progress in the last thirty years has created a new educational group. Years ago when a man graduated from medical school and spent a year of internship, he was prepared for his life's work. There was little likelihood of a need for him to return to the classroom for training because of changes in medical science. Nowadays the opportunity for the physician to avail himself of continuing education is almost limitless. Courses are offered at the medical centers and, in many cases, the courses come to the physician in a traveling clinic arrangement. These postgraduate courses are, of course, most necessary and valuable in keeping the practicing physician in the forefront of knowledge. Fundamentally the postgraduate courses are designed to refresh knowledge once gained or to add to knowledge already basically mastered.

Postgraduate courses in psychiatry, of course, are offered along with the other specialties. The proliferation of these courses has been vastly stimulated by the interest of the National Institute of Mental Health and the American Psychiatric Association. Grants have become available to institutions and groups to offer training in psychiatry for non-psychiatric physicians. Psychiatric postgraduate courses are significantly different from other postgraduate courses. First, the inclusion of psychiatry in the medical school curriculum is relatively recent. Many physicians now in practice have had little formal training in psychiatry. When they return to the school for a course, it will not be refreshing old knowledge or building on that already mastered; some of it will be new.

Secondly, the general practitioner or non-psychiatric specialist appears to be basically resistant to present-day concepts of community psychiatry or preventive psychiatry. For years the physician has been taught that handling the emotionally or mentally ill was not his cup of tea (this was the age when psychiatrists were attempting to achieve equality with other men of medicine) and his patients should be referred to a "trained" physician. Now that psychiatry is established and acceptable, the psychiatrist finds that he has more patients than he can handle or will ever be able to handle. Doing a complete about-face, we say that the G.P. is "at the forefront of contact with the psychological and psychiatric needs of the community"[1] and should come to our courses and get trained. Our request is to help us with a load we first requested that he send to us. It is not surprising that the G.P. resists taking this load back. This perhaps is why it is a nationwide experience that recruitment is difficult for postgraduate courses in psychiatry.[2]

The awareness of emotional and mental disease by the community has created an immense pressure for psychiatric care. Altman concludes that presently trained psychiatric personnel can care for about 1% of the psychiatric problems of our population.[3] It is variously estimated that 10% of the population has a psychiatric disorder which needs treatment, indicating that 90% of those people who need treatment find it unavailable. It is clear from the above sta-

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tistics that simply making the physician able to recognize and refer psychiatric problems will do nothing to help and may well complicate the problem of lack of personnel. The physician must be trained to deal with and treat as many of the emotional disorders as he possibly can. Only in this way will a splash be made in the pool of psychiatric disorders. Only in this way will the G.P. be able to be more than a "middle man" in a psychiatric referral. The psychiatrist should deal with the time consuming and difficult problems of schizophrenia and neurosis for which he was trained.

The methods that have been utilized to teach G.P.s psychiatry are as diverse as education itself: From seminar to supervised clinical experience; from sink or swim to patient contact after six months' didactic lecture; from special topics to vagaries; from one-way screens to movies; the single psychiatrist knocking on doors to the resources of entire psychiatric departments, etc. It seems pointless to survey the methods in detail since extremely little validation has been done against the major problem. This is to say: Can the physician effectively translate what he learns to his practice? Does his referral rate fall and, if so, are his retained patients effectively treated? Does he refer only those that should be referred and effectively treat the remainder? Is the physician comfortable in treating psychiatric patients? No reliable measures of these questions are as yet available and until such time, debate over method is pointless.

The Program

In 1963 the University of Louisville School Medicine, and the State Department of Mental Health were awarded a grant from the National Institute of Mental Health for a post-graduate education course in psychiatry. This course began in September, 1963. The basic objectives of this course are as follows:

1. A practical supervised clinical experience with "typical" office patients.
2. A baseline of didactic work which relates directly to the clinical work.
3. A planned validation program to assess the effectiveness of the course against the need.

Program: Each physician in the program is evaluated by a clinical interview by the course coordinator, a psychiatric knowledge test, an attitudinal survey, and an Edwards Personal Preference Schedule. Each physician is assigned two patients to treat. He sees these patients weekly for sixteen weeks. He sees his supervisor weekly to discuss the nature of the therapeutic progress. Each week one of the physicians will see and treat his patient in the one-way screen, being observed by his peers. A critique by physicians and instructors follows. Didactic material is included. Supervisors record their impressions of changes and learning in the individual and group sessions. At the end of the course, physicians are re-tested as to psychiatric knowledge. The attitudinal survey test and the Edwards Personal Preference Schedule are repeated. A standardized film of a psychiatric interview is shown to all course participants and supervisors and an evaluation questionnaire is given.

Results

1. Intangible: During the two courses given to date, a unanimous impression was gained that therapeutic skills were increased; confidence in handling emotional problems rose markedly; physicians became able to converse with each other about emotional problems without being threatened. One student was amazed that his patients "talked to him now" and another student noted the changes in himself—that he was interested in listening to the patients' problems. Most physicians and instructors felt too much time was spent on didactic instruction; the real benefit seemed to be gained from the screened interview and the highly interactional group discussions.
2. Tangible:
 A. Terminology test:* The terminology test is a ninety-five-item matching test of general information in psychiatry. The original mean score of eighteen errors was reduced to ten errors at the end of the course.

**The attitude tests, the terminology tests and the therapeutic skills tests have been given to groups of psychiatrists and mental health workers. The mean and standard deviations of their results, as well as the "mode" answer for these groups (i.e., most often given answer) are used as baselines. Each physician becomes his own control in that he is tested at the beginning of the course and at the end of the course, and the degree to which he has learned can then be measured for him as an individual as seen by the difference between his first and second scores.*

B. The attitudinal survey* showed that the physicians became much more realistic about mental illness. There was a marked improvement in their concept of the ability of the G.P. to treat emotional problems.

C. The therapeutic skills evaluation* was an ongoing process throughout the program. It was primarily used as an evaluation device during the screening and as a teaching tool by supervisors. There were significant changes registered by peers and by therapeutic self-evaluation. At the end of the course, the therapeutic skills evaluation by the physicians approximated the evaluation by the supervisor. There was a marked change away from a somatic orientation evident in the beginning.

D. At the end of the course, a test film was shown all physicians and a questionnaire was given them as well as to the supervisors. There was essential agreement at the 75% level between physicians and supervisors.

E. The data from the Edwards scale is too sparse to interpret fully at this point, but it did seem that the physician comes to the course with a particular "set," answering questions not as he is, but as he expects others to want him to be. The data suggests that by the end of the course he is much more able to express himself directly.

3. Plans

The second phase of the program begins this year. Repeated testing of the physicians will continue at yearly intervals to determine if gains registered in the course are maintained. In addition, we are attempting to devise a program whereby the effectiveness of the physician in dealing with the emotionally disturbed patients in his practice is measured before and after the course.

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(See Story on Page 710)

Pica and Anemia

John L. Chamberlain, III, M.D.*
Lexington, Ky.

Consider anemia when presented with a child with pica. What may appear to be an iron deficiency may in reality be blood loss.

THE association of pica and iron deficiency has been the subject of recent discussion. Contradictory conclusions have been reached by Lanzkowsky[1] and Gutelius.[2] Studying a group of South African children suffering from pica and iron deficiency, Lanzkowsky came to the belief that when iron deficiency was corrected, pica disappeared. On the other hand, Gutelius and associates found that iron was no more effective than saline in improving pica when she gave it in a double-blind experiment. More recently, McDonald[3] has reaffirmed the findings of Lanzkowsky by the discovery that in his group of children pica could be cured by iron in nearly every case. It is not the purpose of this presentation to seek a resolution to the conflicting experience of others, but to present the history and clinical course of a patient with pica and anemia.

Case Report

A four year old Negro girl was seen at the Lexington Clinic in December of 1963 with the complaint of intermittent abdominal pain of two months duration. Food did not seem to alleviate the pain but self-induced vomiting helped. The child had lost about eight pounds during the course of her illness. Bowel movements were normal. Pica, particularly for paper, became apparent shortly after the onset of her symptoms. Her family and past histories were both unremarkable. There was no history of anemia.

Physical examination was non-revealing. Her weight was 31 pounds and her height was 39½ inches. Blood pressure was 100/40.

Her initial hemoglobin was 4.3 gm./100 ml., hematocrit 27.95 per cent and white blood count 7,900 mm.^{3} Peripheral smear showed 48% granulocytes and 52% lymphocytes. The morphology of the red cells was that of a severe iron deficiency anemia with marked microcytosis and hypochromia. There was no basophilic stippling. The urine was normal. No blood, ova or parasites were present in the stool. Sickle cell preparation was negative. Coproporphyrins were absent from the urine. Direct Coombs test was negative.

She was treated with intramuscular iron with prompt correction of her anemia and disappearance of pica. When seen four months later, she had gained eight pounds and her hemoglobin was 11.45 gm./100 ml.

Her next office visit was seven months later. In the interim, she had done well until approximately one month prior to being seen at which time she began having pica. Physical examination was again normal. Her weight was 35 pounds. Her hemoglobin was 4.16 gm./100 ml. Stool showed 2+ guaiac. Complete x-ray studies of the intestinal tract were negative. Intramuscular iron did not bring about the prompt response that she had before, and the child was admitted for abdominal exploration.

At surgery a small bowel intussusception with a polyp as the bleeding point was found in addition to another smaller polyp just beyond the ligament of Treitz. The patient had an uncomplicated post-operative course. There has been no further abdominal pain, pica or anemia.

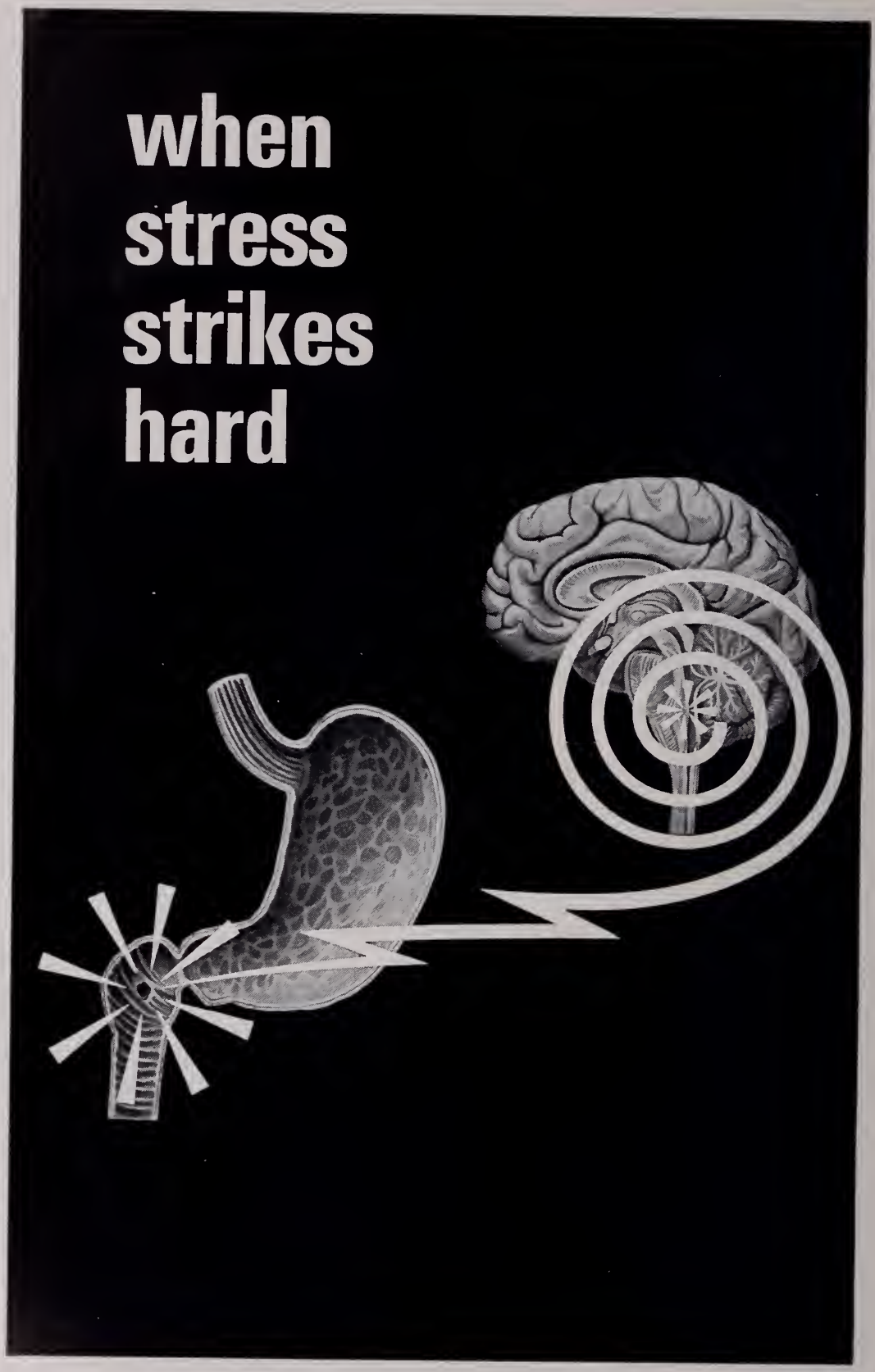
Discussion

The importance of this case to the practicing physician is two-fold. Few observers deny the common simultaneous occurrence of pica and anemia. Controversy exists as to whether pica can be eliminated by correcting the anemia. The findings of this case would seem to support this contention. The discrepancy that has arisen may be the result of

(Continued on Page 726)

From the section on pediatrics at the Lexington Clinic, Lexington, Ky.

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Research in the Service of Medicine

Blastomycosis Involving Bone†

O. James Hurt, M.D.*
Louisville, Ky.

This paper presents a disease entity posing a challenge to diagnostic acumen.

BLASTOMYCOSIS remains a diagnostic problem. The symptoms and findings are suggestive of several disease entities, and it is not unusual for a case of blastomycosis to have more than one change of diagnosis before the final label of blastomycosis is applied. Early diagnosis is important in that it increases the percentage of patients responding successfully to therapy.

North American blastomycosis is a systemic disease caused by Blastomyces dermatitidis, a fungus exhibiting a yeast phase within tissues. This disease is seen mostly in the North American continent, most frequently in the southeastern United States, the Ohio and Mississippi valley areas. It is most common in young adults and in middle life, predominantly in males. The portal of entry is considered to be the respiratory tract but this has not been proven. The disseminated form of blastomycosis carries a poor prognosis, being fatal in 80-90% of cases. The bone lesions are destructive in character and resemble tuberculosis on both gross and microscopic examinations. The bone lesions occur usually in cancellous bone. The changes are predominantly destructive with little or no periostitis, bone production or marginal reaction. In the long bones the involvement is near the end of the metaphysis and the joint is affected secondarily, while in tuberculosis the joint is involved early and primarily. In the spine the diagnosis of tuberculosis is frequently made, later to be changed. Clinically, a confident diagnosis is seldom made until the disease has become widespread. The onset is usually insidious. There may be cough, chest pain and low grade fever. Suppurative and granulomatous lesions may be present. Drainage may be the chief complaint when the patient first seeks medical care and pain may also be a first complaint. The temperature may be low grade initially and progress to febrile levels of 103 to 104 degrees as the disease becomes more advanced. Other than the skin lesions, there is little specifically noted on physical examination. The laboratory offers several aids to diagnosis, but even laboratory findings are not conclusive. The sedimentation rate is increased, there may be hypochromic anemia and leukocytosis with increased neutrophils. Also, more specific tests such as the serological complement fixation test, culture on Sabouraud's medium and skin tests are available. The most reliable test or finding is a positive culture. All of the specific tests may be negative even though the patient is dying of the disease. It is not rare to have the diagnosis made postmortem. Specific therapy started early gives rapid clinical and symptomatic improvement. Even medications given too late cause some temporary improvement. The effective medications are potentially toxic and must be carefully administered. Probably the most effective and most toxic is Amphotericin B. It interferes with the iron transportation mechanism of plasma and suppresses the production of red blood cells with resulting severe anemia. It may also cause renal damage. The next most effective medication is 2-Hydroxystilbamidine. This medication may cause liver damage but does not cause the immediate reactions noted with Amphotericin B. The general opinion is that Amphotericin B should be used if the disease is fulminating in nature and is rapidly progessing. 2-Hydroxystilbamidine may be used if progression is slower. There are usually more recurrences with 2-Hydroxystilbamidine. Surgery, such as excision and amputation, is employed when indicated. SSKI has been used in the past, many times successfully.

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Case Presentations

Case No. 1: A.J.M., 60-year-old white male. This patient was first seen in May 1954, by a dermatologist who diagnosed blastomycosis of the skin. The lesions involved the left wrist, the left prepatellar region and the dorsum of the left foot. The diagnosis was proved by skin biopsy and cultures. He was treated with X-ray therapy and SSKI. The lesions had cleared by May 1955. In August 1955, he had pain in his left wrist. He was seen by an orthopedist but did not give his history. X-rays showed a destructive lesion and he was started on Streptomycin and Cortisone for 25 days, with improvement. He next sought medical attention in March 1956, because of recurrence of wrist pain. A better history was given on this occasion, and he was returned to the dermatologist for treatment. After a course of treatment, he was referred to the Louisville VA Hospital for Stilbamidine therapy. He also gave a history of pain in his right knee of three years' duration. Additionally, he had G.U. complaints. On physical examination it was noted that the thyroid was enlarged and nodular, and the prostate was slightly enlarged but non-tender. Laboratory studies: WBC 5,250, neutrophiles 73, hematocrit 14.7, sedimentation rate 30 mm. per hour, BMR + 10, urea nitrogen 15.5 mg. Culture from prostatic tissue showed no growth. Cultures and tests for Blastomycosis were negative. Biopsy of the left ulnar styloid was interpreted as granulomatous inflammation, probably Blastomycosis. X-ray reported numerous areas of lytic destruction in the left wrist. The right knee was reported as having arthritic changes, and the chest was reported as having no active inflammatory process. While in the hospital he had a 25-day course of Stilbamidine. He had a thyroidectomy, right total and left subtotal, following which he developed hypothyroidism and subsequently was treated for this. He was seen by the orthopedic service and a wrist fusion was advised. He refused this and also refused a recommended course of a 2-Hydroxystilbamidine. He was discharged October 7, 1957, to be followed by his family physician. At that time he was taking SSKI, 40 drops t.i.d., and thyroid, 1-½ gr. daily. He has not been seen since that time.

Case No. 2: R.B., 23-year-old white male. This patient was admitted December 2, 1947, with a clinical diagnosis of possible pulmonary embolism. Chest X-ray taken on admission was read as suggestive of tuberculosis. He had been admitted in August 1947, with a diagnosis of serous pleurisy of undetermined cause. He had also been admitted for appendectomy in November 1947. On examination a tender mass was noted on the right posterior chest about the eighth rib. Laboratory studies: RBC 3,620,000, sedimentation rate 66 mm. per hour. Culture of drainage from chest was positive for Staphylococcus aureus and negative for fungus. X-ray report of October 13, 1948, of the dorsal spine "—findings are most suggestive of tuberculous spondylitis." Course in the hospital: This patient was admitted with a diagnosis of possible pulmonary embolism. This diagnosis was changed to possible tuberculosis shortly after admission. Biopsy of the tumor of the thoracic wall was done December 16, 1947. Following this the ninth rib was resected, and the diagnosis of tuberculosis was made. Patient was started on Streptomycin and Penicillin. He also had a sternal biopsy. On April 6, 1948, a review of hospitalization was done and the diagnoses under consideration were (1) granulomatous lesion due to tuberculosis; (2) myelogenous leukemia; (3) multiple myeloma; and (4) fungus infection. Continued efforts were made to establish a diagnosis and a culture report of October 15, 1948, from the Air Forces Institute of Pathology was Blastomyces dermatitidis. This was confirmed by Duke University. Following this he was started on SSKI, and was discharged January 4, 1949. At that time his sedimentation rate was 6 mm. per hour. While in the hospital he had had a low fever. This patient was followed in the orthopedic clinic until July 13, 1955. His blood count and sedimentation rate had remained satisfactory.

Case No. 3: E.C., 40-year-old white male. This patient was admitted March 18, 1963, with a diagnosis of chronic infectious spondylitis of the lumbar spine; possible tuberculosis; possible fungus. He had had pain in his back for 18 months. He noticed a swelling in his right flank in September 1962. X-ray taken in December 1962, showed a disease process at the L-1—L-2 level. I & D was done. Following this he was admitted to the Lexington VA Hospital and transferred to the Louisville VA Hospital. On physical examination a

draining sinus was noted on the right lower abdomen. Hemolytic Staphylococcus aureus was cultured from this. His lumbar spine was tender. Laboratory studies: WBC 9,420, sedimentation rate 48 mm. per hour, PPD intermediate strength strongly positive at 24 and 48 hours. Tuberculosis and fungus cultures were negative. X-ray findings were compatible with chronic infection, with fungus disease to be ruled out. He insisted on discharge after one week. He was discharged in a brace and on tuberculosis therapy. He was readmitted June 18, 1963, with increased symptoms. WBC 9,670, sedimentation rate 55 mm. per hour, hemoglobin 9.3. After further treatment he was again discharged on bed rest and tuberculosis therapy. His progress was followed in the orthopedic clinic. When his condition worsened sufficiently he consented to readmission January 30, 1964. Since he had gotten much worse while on tuberculosis therapy, blastomycosis was strongly suspected and reinvestigated. His sedimentation rate was 56 mm. per hour, urea nitrogen 72 mg. %. He had developed neurological symptoms of the lower extremities. His temperature was 104 degrees. A skin lesion on his finger was recognized as blastomycosis, and the organism was found in the material obtained. During this interval pulmonary symptoms had presented. Fungus serology done by the Serology Research Laboratory at the VA Hospital, Memphis, Tenn., was positive at 1:8 February 3, 1964, and 1:32 February 19, 1964. Amphotericin B was started. He was anemic and received four units of blood. He improved for about ten days, following which his condition progressively deteriorated. He died March 16, 1964.

Case No. 4: T.H., 53-year-old white male. This patient was admitted March 4, 1964. His complaints were progressive weakness, dysuria, nocturia and frequency of four weeks' duration. He had no G.U. complaints previously. On examination he was found to have an enlarged, firm, smooth prostate. He was admitted for possible prostatic surgery. Laboratory studies: Hemoglobin 13.1, WBC 8,320. His symptoms subsided shortly after admission. He was given leave March 18, and on his return March 31, he had swelling of the left foot. X-rays were negative. X-ray of the chest made March 5, 1964, was read as (1) diffuse interstitial fibrosis, (2) pneumoconiosis. Skin lesions developed, recognized as blastomycosis, and the organism was found in prostatic smear and skin scrapings. The serologic tests were negative, as were the skin tests. Sedimentation rate was 40 mm. per hour April 1, 1964. Amphotericin B was started April 23, 1964. The skin lesions improved. A septic type fever continued and the patient gradually deteriorated. He died May 24, 1964.

Summary

Blastomycosis involving bone is relatively rare. The diagnosis is delayed if the examiner does not consider this disease in his differential diagnosis. It should be considered when the possible diagnosis is tuberculosis, metastatic tumor, multiple myeloma, Ewing's tumor, syphilis, bone cyst or osteomyelitis. It is most commonly mistaken for tuberculosis. All cases of chronic infection in which the manifestations are atypical and the diagnosis cannot be established readily should be considered as possible fungus infection, blastomycosis being one of the most common. Even though blastomycosis is suspected early, the diagnosis is difficult to prove and many times can be establish only after the disease has become far advanced. This of course lessens the percentage of cure or arrested cases. We should therefore be persistent in the pursuit of a positive diagnosis as long as blastomycosis remains a posibility.

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CASE DISCUSSIONS
From The
University of Kentucky Hospitals

Menopause, Mental Illness and Meningiomas

Charles B. Wilson, M.D.*

THE following account concerns a middle-aged lady who became a problem to her family as she passed through the menopause. Inappropriate behavior and a change in personality were the outstanding manifestations of her illness. The referring physician suspected an underlying organic process rather than a functional psychiatric disorder and his suspicion was confirmed. The steps which led to the discovery of a benign brain tumor illustrate certain features which separate organic from functional mental disease.

A 49-year-old female was admitted to the Psychiatric Service at the University of Kentucky Hospital on 9-10-64 for evaluation of progressive mental changes. Her behavior had become increasingly intolerable to the family during the previous two years. The patient had a belief that women often lost their minds during menopause, and she feared that she, too, would become "crazy". She was overanxious and overprotective with her two younger children. She made frequent telephone calls to members of the family, telling each how badly the others were behaving. Her behavior was inappropriate on several occasions, the most embarrassing event being a loud denunciation of her son during a church service. Formerly shy and reserved, she became loud, demanding and critical.

Several generalized convulsions had occurred since 1947. These were infrequent and she received no medication until 1962 when she sustained a fracture of the left humerus during a seizure. Dilantin and phenobarbital were prescribed and for two years she was seizure-free. One generalized seizure occurred three months prior to admission.

She became aware of increasing weakness in the left leg over the course of several months. This caused her to fall immediately prior to admission resulting in a comminuted fracture of the left patella.

An electroencephalogram obtained by the referring physican was reported to be abnormal without distinctive features. This finding prompted her admission for psychiatric and neurologic evaluation.

Physical Examination

She was preoccupied with a fear of losing her mind, yet she was inappropriately cheerful. Her thought content revealed paranoid ideation. She was oriented in all spheres and memory was not defective. Her attention span was brief, and commands and questions frequently had to be repeated.

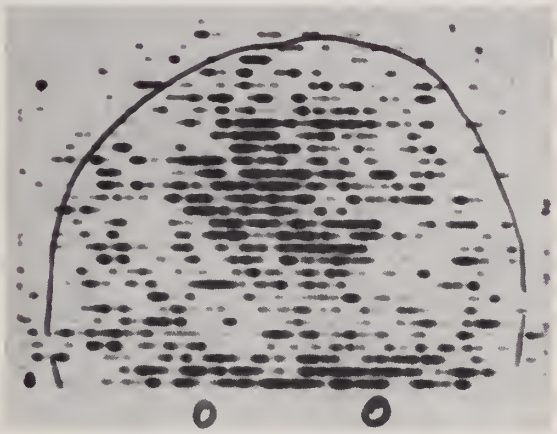


FIGURE 1. Radioactive mercury brain scan showing a large area of increased uptake involving both frontal lobes.

The patient was slightly overweight. The general physical examination was normal except for a limited range of motion in the left shoulder. The left leg had been placed in a plaster cast.

Neurologic examination disclosed forced grasping reflexes bilaterally, slight relative hyperactivity of deep reflexes in the left arm and a Babinski sign on the left. The optic discs were normal.

A small hyperostotic area in the right frontal bone was seen on plain films of the skull.

Psychologic testing indicated organic impairment. Judgement was poor and inconsistent. In combination with the reports of inappropriate social actions with professional personnel on the ward, her faulty judgement raised considerable doubt regarding her understanding of the seriousness of her condition.

Additional studies were recommended by the consultant in Neurology who made a provisional diagnosis of a right frontal lobe tumor. An electroencephalogram indicated a right frontal mass lesion. A brain scan with radioactive mercury revealed a large area of increased activity in the midline extending into both frontal lobes (Figure 1).

The patient repeatedly expressed her decision not to undergo surgery should a brain tumor be discovered. She reluctantly consented to carotid angi-

*Assistant Professor and Chairman, Division of Neurosurgery, Department of Surgery, University of Kentucky School of Medicine, Lexington, Kentucky



FIGURE 2. Right carotid arteriogram showing vessels stretched around a frontal mass.

ography at the urging of her psychiatrist. The procedure was performed on 9-21-64 and a large bilateral frontal parasagittal mass was shown (Figure 2). A tentative diagnosis of parasagittal meningioma was based upon the total information at hand. She consented to surgery at the insistence of her family.

Craniotomy was undertaken on 9-28-64. A meningioma weighing 300 grams was totally removed. The bone flap in the right frontal region had been invaded by tumor and the flap was removed and boiled to destroy viable intraosseous tumor cells.

Her postoperative course was uncomplicated and she was transferred back to the Psychiatric Service on 10-3-64 where she remained until being discharged on 10-12-64.

The patient was admitted for the second time on 11-25-64 because of jaundice and nausea during the previous 11 days. A diagnosis of serum hepatitis was supported by laboratory studies and she was transferred to the Medical Service. Improvement in liver function was rapid and she was discharged on 12-6-64.

The family reported a return of her personality to near-normal. An interview during the second hospital admission confirmed an improvement in her mental status.

Discussion

The onset of convulsive seizures in adult life is a clear indication for neurologic evaluation. The initial screening procedures ordinarily include a neurologic examination, plain films of the skull and an electroencephalogram, all of which were abnormal in the present case. Further diagnostic procedures which do not require hospitalization are lumbar puncture and radioactive brain scan. Lumbar puncture is contraindicated if the diagnosis of a brain tumor is suspected on the basis of foregoing studies because a definitive contrast study is indicated regardless of the findings by lumbar puncture, a procedure which is not without danger.

Tumors of the frontal lobe are often notoriously subtle in their manifestations. Frontal tumors may produce mental changes with little or nothing in the way of motor or sensory abnormalities. Psychologic testing and psychiatric evaluation usually permit a clear distinction between organic mental changes on the one hand, and psychosis or psychoneurosis on the other. A psychiatric consultation may be met by objection from the patient or the family or both, in which case the problem may be approached from another angle through the medical or surgical neurologist.

Mental institutions, state and private, contain a small number of patients with brain tumors. The tumor most often encountered in this situation is a frontal meningioma. Temporal lobe tumors may cause mental changes but are less often confused with functional psychiatric disease. Meningiomas are slow-growing tumors with a life history measured in terms of many months or years. The insidious development of mental changes caused by a meningioma is more likely to deceive the physician than the more fulminating course of malignant frontal tumors.

Finally, the successful control of convulsive seizures following the institution of therapy with anticonvulsant drugs should not be taken to indicate a benign or non-specific etiology. Just as aspirin has an antipyretic action whatever the cause of fever, anticonvulsant drugs simply raise the seizure threshold in a non-specific manner. The majority of seizures of diverse etiologies can be largely or entirely controlled with adequate medication. A convulsive disorder should be considered as a symptom of disease and not a disease of itself. The number of cases termed "idiopathic epilepsy" diminishes as these patients are subjected to careful study. Correctable causes of epilepsy will be discovered if each patient with a convulsive disorder is considered a diagnostic problem. A basic evaluation will permit the selection of certain cases for further study by angiography or air encephalography.

SPECIAL ARTICLES

The Committee on Medicine and Religion

JOSEPH H. SAUNDERS, M.D.*
Lexington, Ky.

IN 1961 the Board of Trustees of the American Medical Association established the Committee on Medicine and Religion and appointed as its director, the Reverend Paul B. McCleave, LLD. Shortly thereafter the Board of Trustees of the Kentucky Medical Association established a State committee on Medicine and Religion to have as its purpose "the creation of a better understanding between the clergy and the physician in order to bring about improvement of total patient care". To date, 49 states have established through their state societies these committees of medicine and religion and this is rapidly developing into a new approach to total patient care. A great deal of interest has been shown by the clergy in these programs as they feel that it is opening up a new area in their associations with physicians as well as giving them a better insight into the problems which physicians face and which in turn will give the physician a chance to understand the problems that the clergy must face with their congregations.

It has long been known that many cases of illness are precipitated by external influences and life patterns themselves. Very often a minister has special insight into a family situation similar to the picture which a general practitioner has in a small town or even in a large city. In addition, the minister has an association with the patient that the doctor does not have and this concerns his religious beliefs and faiths. Terminal illnesses may give rise to complex problems and situations especially if the illness is of an acute nature and affect the lives of the patient's family and his business. In these cases alone, the minister may have a background of personal contact which can be of great help in advising the family.

Also, what might be done in illnesses where so-called extraordinary measures may or may not be utilized in maintaining life. Regardless of the depth of the religious faith of the doctor or his complete lack of it, the religious convictions and faith of the patient are of great importance. This program is in no wise an attempt to evangelize nor to convert, but to lead to a better understanding of these religious convictions as an aid in the total care of the patient.

Most doctors are ready to enlarge and improve their horizons philosophically and medically. It has been repeatedly proven that both doctors and ministers will be benefited by the program as it develops.

Those of the State committee will be ready to give your county society help in establishing this program locally. The clergy have demonstrated their interest in this new approach to better understanding and cooperation between medicine and religion. The Committee on Medicine and Religion of the State Medical Association will have a booth at the annual convention in Louisville to explain the program and to conduct taped interviews regarding its many ramifications. They invite you to stop by and visit and learn about the program and take part in its development.

* *Doctor Saunders is chairman of the KMA Committee on Medicine and Religion. Others on the Committee are John Bickel, M.D., Owensboro; Avrom M. Isaacs, M.D., Louisville; Harold Keen, M.D., Bowling Green; John R. Stevie, M.D., Covington, and Lewis E. Wesley, M.D., Liberty.*

EDITORIALS

Our Fourth Concern

SINCE man first learned to ferment grain, fruits and plants, the use of alcohol has constituted an ever increasing problem to society. It is one that is as old as tuberculosis, venereal disease and mental illness. No country nor status of society has been free from its effects. Unfortunately the United States is progressing toward the top among the nations in which it is a major concern.

By combined effort of medical science, research and public demand, we have approached an effective control of tuberculosis and venereal disease and are making noteworthy progress in the management of mental illness. This has been less true with respect to alcohol. At present it is the major contributing factor in traffic fatalities with direct causative relation in perhaps 50% of all such in the United States. It is a contributing factor in about 25% of admissions to mental institutions. It is a major cause in decreased industrial production and one of the principal reasons for crime, domestic discord, divorces and disruption of family life. Its abuse is almost if not quite as prevalent among women as among men. It ranks fourth among causes of death.

During the last ten years there has grown a very widespread and increasing interest toward a combined effort of all concerned to attempt a solution of the problem. Industry has undertaken varied and sometimes effective means in combating the devastating effects of alcohol at all levels, from the production line to the executive office. Traffic control and law enforcement officers have sought to educate and to warn the public by every available means of communication. Teachers, ministers, counselors and physicians have undertaken to contribute their part to find a proper solution.

The responsibility of the hospital is a key factor in the management of victims of alcohol. Heretofore it has been the policy of public and often of private institutions to decline for admission and treatment the acute or sometimes chronic alcoholic. This has been unfortunate because, aside from the general hospital, there have been few institutions or clinics or provisions in any community set apart to administer to the needs of the alcoholic such as have been provided for the patient with venereal disease or tuberculosis or mental illness. With the present crowded conditions of our general hospitals it of course appears to be a travesty for a patient with acute alcoholic intoxication to occupy the last bed available and as a result the critically ill patient with a coronary occlusion, perforated peptic ulcer, acute surgical disease or severe bodily injury to be refused admission. Of late, however, there has been a change in the policy of some of these institutions, and a more sympathetic attitude toward their responsibility in helping the acute or chronic victim of alcohol.

A generation ago the Keely Institute at Dwight, Illinois, received and treated alcoholics with considerable success. William B. Terhune, M.D., of New Cannan, Connecticut, has done a remarkably good job in institutional care during recent years. Alcoholic wings or divisions are operated in some general hospitals, but for one reason or another many of them have been discontinued. Private Sanatoria for this purpose are usually short lived—two were operated in Louisville but both were discontinued a decade ago. We are really without adequate facilities unless our general hospitals relax their restrictions.

There has been the feeling that the treatment of alcoholism in any form is primarily a problem for the psychiatrist. This does not turn out actually to be the case. Sympathetic attention of

the attending physician whether he be surgeon, general practitioner, internist, or engaged in any other field of practice, affords the greatest and most effective help to the person acutely or chronically incapacitated from the effects of alcohol. Sympathy for him and his problem, a willingness to learn the personal and emotional background that have caused the patient to resort to drink and an intelligent effort to help in the solution of these factors, cooperation with the family in their efforts are often more effective than the formal consultation, advice and treatment of the psychiatrist. It is an area in which we all have a great responsibility and in which an intelligent and flexible approach is often effective.

We have all seen the middle aged or older individual of culture, refinement and religious habits come, for one reason or another, to the excessive use of alcohol and become an unexpected liability. We have also seen the habitual drunkard awaken to his unfortunate state, respond to the entreaties of his employer, family, his minister or his physician, and resume a respectable, productive and honest place in society. It is not by any means so nearly a hopeless disease as malignancy, narcotic addiction or the changes in arteriosclerosis.

Society has imposed a very serious handicap upon people by excessive use of alcohol as a social custom. The encouragement or condonement of drinking among teenagers and young people is the basis for much of our present difficulty. Too often the adult participant in an evening's entertainment, business conference or cocktail party leaves in a physical and mental state conducive to his and others' death before he reaches home, not to mention the family discord after he gets there and inefficient work production the following day.

A generation ago alcohol was about the only effective medication in peripheral vascular disease which we knew and it was prescribed frequently. It was advised by physicians as a tonic, a sedative and appetizer. Fortunately far better medications have been devised for all of these and other purposes and it is doubtful whether a physician should ever advise the use of alcohol as a medication. The sanction of its use by his physician is not infrequently given as the beginning and the basic cause of chronic alcoholism.

We know the remedy for the population explosion, but people are reluctant to practice it. Excessive obesity can be prevented or controlled if its victims can be induced or inspired to practice the self discipline and persistence required. Likewise the means for the prevention and cure of alcoholism is available if people can be guided or helped to avail themselves of it. The community hospital and physicians of all specialties cannot deny nor escape their responsibility in this matter. We must try to do better.

SAM A. OVERSTREET, M.D.

Houston – November 1st To 4th, 1965

HOW LONG since you have been to Houston, the oil capital of America? Have you visited this metropolis of the Southwest during the past five years? If you revel in the past you will want to see the mighty battleship Texas moored on the canal adjacent to the San Jacinto battleground where General Sam Houston defeated General Santa Anna on April 21, 1836 to assure Texas' independence. If you look to the future you will see the space center and the world's largest air conditioned sports arena. Houston is one of the most rapidly growing and progressive cities in the United States.

You will enjoy going there to attend the fifty-ninth annual meeting of the Southern Medical Association. It is the largest regional medical body in the United States with a membership approaching 20,000 drawn from the seventeen southern states: there are about 800 Kentucky members, an increase of nearly 100 during the past year. You will enjoy visiting the Medical Center, Baylor University School of Medicine and University of Texas Medical School at nearby Galveston.

The traditions of the south prevail as in few other organizations. The courtesy, the hospitality, the leisurely manner of genteel living

and cordial social relations are found, not greatly altered by the fuss and fury of the present era. Even the heat will be tempered to your taste.

The scientific program will appeal to you, whatever may be your special interest. There are fourteen sections. Attendance is always good but not such that the meetings lose their character of intimacy and freedom to ask questions or to present a personal viewpoint in discussion. Guest speakers from outside the area add much to each sectional program—panel presentations are used liberally, adding greater breadth to accumulated clinical experience.

Headquarters for the Southern Medical Convention will be at the Rice Hotel. Requests for reservations should be sent to the SMA Housing Bureau, 1006 Main Street, Suite 1101, Houston, Texas. Secure a suitable reservation early. Enjoy the excellent scientific program and the many social events prepared for you and your wife. Maybe you will want to visit nearby Mexico, quiet and friendly now, since The Raven won the battle of San Jacinto.

SAM A. OVERSTREET, M.D.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater leadership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

ORGANIZATION SECTION

Dr. Crane to Discuss American Political Dilemma at Lunch

The acute problems facing our nation will be explored by Philip M. Crane, Ph.D., Bradley University, when he speaks on "The American Dilemma" at the President's Luncheon September 22 during the KMA Annual Meeting.



Doctor Crane

Delmas M. Clardy, M.D., Hopkinsville, in releasing additional information on the luncheon, spoke of Doctor Crane as a "dynamic young speaker with an intelligent and practical grasp of the involvements on the political scene. His speech will be of vital interest to any physician concerned about the future of his profession and his country."

Doctor Crane is a well known lecturer, author, and historian. His book, "The Democrat's Dilemma", was widely acclaimed for its coverage of the growth of the Fabian Socialist movement in American politics.

A recipient of both master's and doctor's degrees from Indiana University, his academic record there has never been excelled. Doctor Crane also studied at the University of Michigan and the University of Vienna. He taught history for three years at I.U. before going to Bradley, where he is assistant professor of history.

He is on the Advisory Board of the Illinois Young American's For Freedom, on the Advisory Assembly of the American Conservative Union, vice president of the Educational Foundation for Human Rights, and president of the American Public Affairs Educational Fund, Inc.

The Luncheon will be held in the Terrace Room of the Kentucky Hotel at 11:50 a.m. Wednesday. Doctor Clardy urged that all KMA members make a special effort to attend.

AMA Encourages Blue Shield Role in Medicare Program

The nation's Blue Shield Plans have been encouraged by the American Medical Association to play an important role in the administration of the physician services portion of the new Medicare Law.

The AMA responded to a request for guidance by the National Association of Blue Shield Plans on the part member Plans should take in the administration of the supplementary medical insurance program of PL 89-97, the new Medicare Law.

In commenting on the AMA stand, John W. Castellucci, executive vice president of the Blue Shield group, said that Blue Shield should play an important part in the medical-surgical portion of the law for three reasons: its role in medical prepayment plans with 56 million members, including five million aged; the active participation in Blue Shield of more than 150 thousand practicing physicians; the fact that it would take a strong carrier with long-established relationships with both physicians and patients to administer this program.

Ky. M.D.s to Hear Legislators At KEMPAC Sept. 20 Seminar

Two distinguished legislators representing both major political parties will be the featured speakers on the KEMPAC political seminar program Monday evening, September 20 during the KMA Annual Meeting.

The annual banquet and educational seminar, sponsored by the Kentucky Educational Medical Political Action Committee, will be held in the Flag Room of the Kentucky Hotel beginning with a social hour at 6:00 p.m., according to Richard F. Greathouse, M.D., Louisville, secretary of the KEMPAC Board of Directors.

Ralph W. Yarborough, Democratic Senator from Austin, Texas, will participate in the program as the representative of his party, Doctor Greathouse announced. Senator Yarborough was first elected to his present office in April, 1957 to fill the vacancy left by the resignation of Senator Price Daniel, and has been re-elected twice since that time.

He holds an L.L. B. degree from the University of Texas Law School, and held numerous local and state offices before his election to the Senate.

John R. Kernodle, M.D., Burlington, N.C., secretary-treasurer of the American Medical Political Action Committee, will also appear on the program, Doctor Greathouse said.

Senator Peter H. Dominick, (R), Englewood, Colo., will represent the Republican party. Senator Dominick has represented his state in Congress since 1962. Additional information on the Senator from Colorado appeared in the August issue of The Journal.

Scientific Exhibits to Feature Latest Research, Techniques

Twenty-one scientific exhibits on various subjects have been approved for the Annual Meeting by the KMA Scientific Exhibits Committee and will demonstrate medical progress and the latest in medical research, according to Benjamin B. Jackson, M.D., Louisville, chairman of the committee.

The exhibits will occupy 880 square feet of floor space and will be located in the area between the technical exhibits and the general sessions. Certificates will be presented to all exhibitors and a plaque will be awarded to the sponsor of the exhibit judged to be the most outstanding.

A list of exhibitors follows:

Hand Arteriography
T. R. Marshall, M.D., Willard F. Chumley, M.D., Morton L. Kasdan, MD., and David Neustadt, M.D.
University of Louisville School of Medicine

Vector Cardiography
F. A. Olash, M.D., Leonard Leight, M.D.
University of Louisville School of Medicine

Current Clinical Research at the National Institutes of Health
C. K. Himmelsbach, M.D.
National Institutes of Health

Lumbar Discography: A Twelve Year Experience
John S. Collis. Jr., M.D., W. James Gardner, M.D.
Cleveland Clinic

Mammography
R. Burke Casper, M.D., Bernard F. Sams, M.D., Edward N. Maxwell, M.D.
St Joseph's Infirmary, Louisville

Heart Block, Countershock and Electrocution
George F. Brockman, M.D.
Greenville, Ky.

Computers and Medical Information
Kornhauser Medical Library
University of Louisville School of Medicine

Fertility Control Through the Ages
Ralph R. Robinson, M.D.
Middlesboro, Ky.

The Management of Traumatic Injuries to the Head and Neck
Paul M. Weeks, M.D., Andrew M. Moore, M.D.
University of Kentucky Medical Center

Overall Management of Geriatric Patients With Chronic Brain Syndrome
Francis H. Stern, M.D.
Philadelphia, Pa.

Muscle Conservation in Radical Mastectomy
George B. Sanders, M.D.
Louisville, Ky.

Pulmonary Embolism
Benjamin B. Jackson, M.D.
Louisville, Ky.

University of Kentucky Medical Center
Lexington, Ky.

Effect of Drugs on Human Performance Under Stress
Audrey Holliday, Ph.D., Robert P. Sharpley, M.S.
University of Washington

Package Disaster Hospital
Kentucky State Department of Health

Tracheostomy
R. B. McElvein, M.D., W. Porter Mayo, M.D.
Lexington, Ky.

Studies in Infant Feeding: Incidence of Colic and Gastrointestinal Disturbances
Lawrence Breslow, M.D., I. Robert Plotnick, M.D.
Lutheran General Hospital
Chicago, Ill.

Differential Diagnosis of Syphilis
Kentucky State Department of Health

Radney Gets Zapped
Kentucky State Department of Health

Intra-Uterine Contraceptive Device (IUCD)
Bernard Schneider, M.D.
Louisville, Ky.

Prevention of Acute Renal Failure
Mohammad Atik, M.D.
University of Louisville School of Medicine

Effects of Tybamate on Depressive and Anxiety States in Penitentiary Innmates
Harry Brick, M.D.
Virginia State Penitentiary

Message Center at KMA Meeting Serves in Emergency Calls

Your telephone number during the KMA Annual Meeting September 21-23 will be **584-2201 (Area Code 502)**, the number of the message center located in the middle of the Technical Exhibit Hall at the Louisville Convention Center.

If you wish to be contacted by home, office, or hospital while attending the meeting, leave this number with potential callers. *Only emergency calls* will be posted on the blackboards in the entrance lobby and the Scientific Assembly Hall. All messages will be on file and may be picked up at the message center. You are urged to check there frequently for calls.

The phone number of the Kentucky Hotel is **587-1181**. If you wish to be reached Monday, September 20 at the first meeting of the House of Delegates, or Wednesday evening, September 22, at the second session of the House, the call should be directed to the Terrace Room.

If you wish to locate friends who are also attending the meeting, just call 584-2201 and leave a message to be delivered. For your convenience in receiving calls and messages quickly, you are urged to make full use of the message booth.

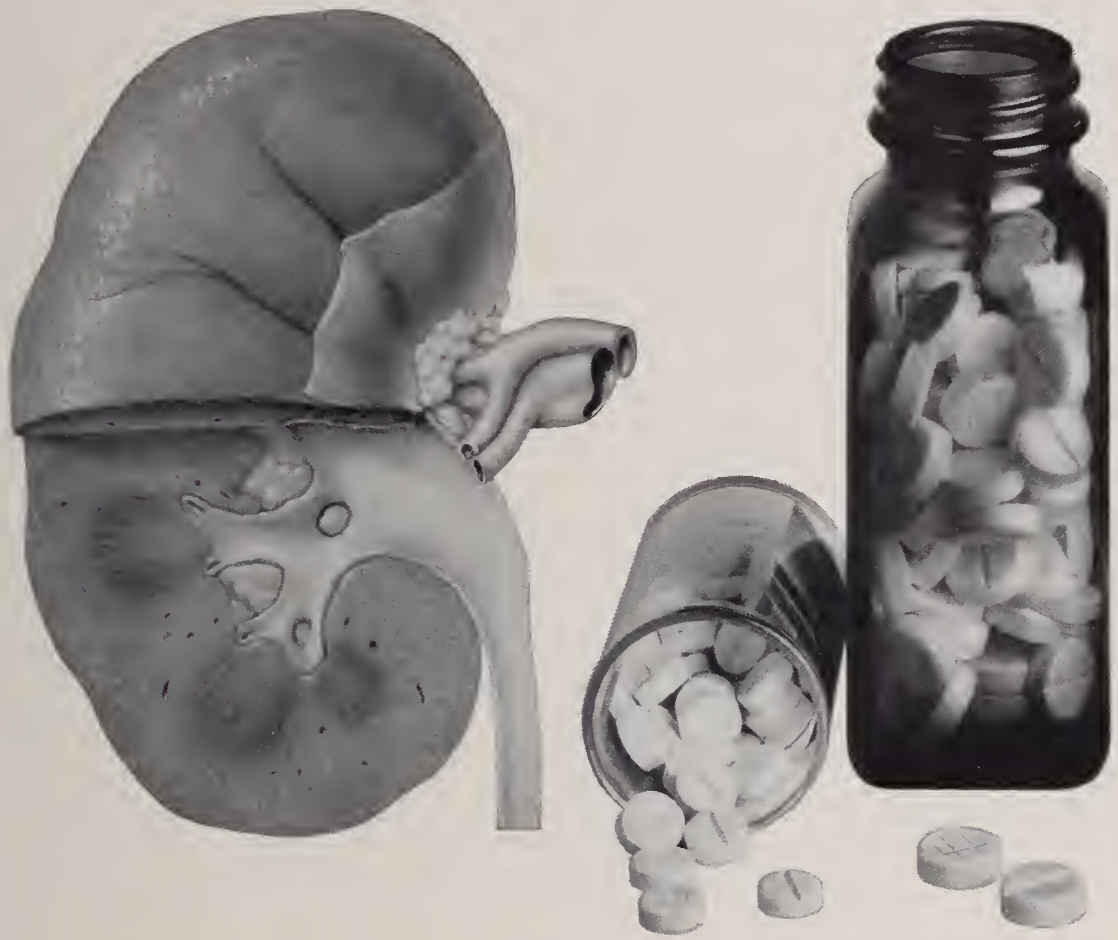
The message center will be staffed by trained personnel of the Southern Bell Telephone Company, sponsor of the message facilities.

U.S. Disaster Care Session Set

The 16th National Conference on Disaster Medical Care will be held Saturday and Sunday, October 30 and 31 at the Drake Hotel in Chicago. William T. Rumage, Jr., M.D., chairman of the KMA Disaster Medical Care Committee and a member of the AMA committee, is chairman of the National Conference.

KMA members are cordially invited to attend the two-day symposium which will feature "Care of the Traumatized Patient," "Disaster Communications," and "Disaster Planning in Industry." Details can be obtained by writing the KMA Headquarters Office.

at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

KMA Golf Tourney Site Changed To Hunting Creek Club

The new Hunting Creek Country Club, located five miles east of the Watterson Expressway on U.S. 42, near Louisville, has been designated as the site of the 1965 KMA Golf Tournament September 20, it was announced by James B. Douglas, M.D., chairman of the Golf Committee.

The Hunting Creek Club golf course replaces the Louisville Country Club as the location for the tournament, due to repairs that will be in progress at the latter course on that date, Doctor Douglas said.

He pointed out that tournament participants coming to Louisville from the East & South will not find it necessary to go into the city, but may go directly to the club.

Conditions and fees for tournament play will be unchanged from the arrangements made with the Louisville Country Club. Doctor Douglas stated that while the necessity for change is regrettable, "I feel fortunate in being able to arrange for the facilities of the Hunting Creek Country Club, and believe we will have a very successful tournament on its fine golf course".

U. L. Alumni Schedule Reunions During KMA Annual Meeting

Individual dinners and parties have been arranged for most of the ten University of Louisville Medical School classes having reunions during the KMA Annual Meeting in Louisville this month.

In addition to the cruise on the Belle of Louisville, which is set for Tuesday evening, September 20, beginning at 6:00 p.m., several classes have made plans for separate get-togethers. For additional information on your own class reunion, please get in touch with your chairman listed below. Also listed are such functions as have been scheduled as we go to press.

1915—No Chairman; class to be guests of U. of L. at KMA President's Luncheon Wednesday, September 22

1920—No chairman

1925—Everett H. Baker, M.D., Louisville

1930—Clifford Wilson, M.D., Kansas City, Mo., chairman; Richard R. Slucher, M.D., Louisville, co-chairman; Dinner, 6:00 p.m., Wednesday, September 22, Kunz's Restaurant

1935—Paul Mapother, M.D., Louisville; Stag dinner and social hour, Big Springs Country Club, 5-9:00 p.m. Wednesday, September 22

1940—E. P. Scott, M.D., Louisville; Dinner, 6:30 p.m., Mirror Room, Kentucky Hotel, Wednesday, September 22

1945—Robert B. Nolan, M.D., Louisville; Social Hour, Dinner and Dance, 6:00 p.m., Audubon Country Club, Wednesday, September 22

1950—Hoyt D. Gardner, M.D., Louisville; Dinner, 6:00 p.m., Pendennis Club, Wednesday, September 22

1955—C. Ray Potts, M.D., Louisville; Dinner, Executive Inn, 6:00 p.m., Monday, September 20

1960—David F. Archer, M.D., Louisville; Reception, 5-8:00 p.m., Executive Inn, Wednesday, September 22

Ky. Rural Health Conference Set Oct. 21 at Hopkinsville

"A Profile of Health Services, Resources, and Unmet Needs in Western Kentucky" will be the theme of the 13th annual Kentucky Rural Health Conference October 21 at Hopkinsville, according to John E. Cotthoff, M.D., Hopkinsville, Conference chairman.

The Conference is sponsored by the Kentucky Rural Health Council. Doctor Cutthoff said the program is being planned by a committee of the Council with the assistance of Donald L. Graves, M.D., Frenchburg. The Council was originated by KMA and is composed of 27 member organizations.

Governor Edward T. Breathitt has tentatively agreed to appear as the luncheon speaker for the session. Delmas M. Clardy, M.D., Hopkinsville, KMA 1964-65 president, will represent the Association.

Other physicians on the program include William T. Rumage, Jr., M.D., Louisville, chairman of the KMA Disaster Medical Care Committee; Joseph Hamburg, M.D., assistant professor in the department of community medicine at the University of Kentucky College of Medicine, and W. Faxon Payne, M.D., president of the Hopkinsville Chamber of Commerce.

The primary aims of the conference are to enlist local leadership in meeting the health needs of the rural population, to promote cooperation and understanding among professional people interested in improving rural health service and facilities, and to raise the standards of medical services, sanitation, and disease prevention in rural areas.

County Health Chairmen to Meet

Each county medical society is urged to have its school health committee chairman to meet at 3:00 p.m. in room 207 of the Convention Center on September 21. O. B. Murphy, M.D., Lexington, chairman of the KMA School Health Committee, said the purpose of the meeting is to discuss the medical professions's participation in matters of physical education and sports in Kentucky's school system.

Delegates' Coffee Break Planned

Again this year the Kentucky State Association of Medical Assistants will serve at a coffee break for the KMA House of Delegates at its first meeting on Monday morning, September 20 during the Annual Meeting. The KSAMA will also have a booth at Convention Center to inform interested persons of their organization.



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



KAGP Oct. 7 Maysville Seminar Program Announced

A half-day scientific program concerning a variety of topics of interest to the general practitioner has been scheduled for the Kentucky Academy of General Practices October 7 Seminar at Maysville, according to John T. Teegen, M.D., Maysville, program chairman.

Registration will begin at 12:30 p.m. at the Mason County Health Department. Following is the complete program:

1:00 p.m. **"Management of Rh Sensitized Pregnancies and other Complicated Pregnancies"** John L. Duhring, M.D., assistant professor of obstetrics and gynecology, University of Kentucky

2:00 p.m. **"Common Foot Problems in Children"**, John C. Schmerge, M.D., Cincinnati

3:00 p.m. Recess

3:15 p.m. **"Diagnosis and Treatment of Chronic Lung Disease"**, W. Porter Mayo, M.D., assistant professor of clinical surgery, University of Kentucky

4:15 p.m. **"Current Research in Laser Progress"**, Leon Goldman, M.D., director of Laser Laboratory and professor of dermatology, University of Cincinnati

6:00 p.m. **Social Hour, Maysville Country Club**

7:00 p.m. **Dinner, Maysville Country Club** (Subscription)

8:00 p.m. **"Murder?"**, Rudolph J. Muelling, M.D., director, division of toxicology and forensic medicine, University of Kentucky.

Wives are invited to attend the social hour and dinner. During the afternoon they will be entertained by members of the Mason County Medical Society Auxiliary. Golf Course privileges at the Country Club will be extended to any physician who wishes to play before the Seminar. All physicians are cordially invited to attend the scientific meeting. There is no registration fee.

Nov. 14-20 Diabetes Drive Goal Is Finding, Treating Victims

"Finding unknown diabetics and helping them to live longer, more useful lives is the goal of the annual Diabetes Detection and Education Drive during the week of November 14-20," according to Irving F. Kanner, M.D., Lexington, chairman of the Kentucky Medical Association's Diabetes Committee.

This will be the 15th year in which a public service effort of this kind has been made in Kentucky. During the 14 previous drives, more than 2,200 cases of diabetes have been found. During 1964, all previous records were broken in the number of tests reported and number diagnosed as new diabetics—103,248 free tests were made and 230 proven cases reported.

Doctor Kanner urges all Kentucky Physicians to take part in the program, to order their supply of free clinistix from their county chairman, and to check urine samples free during the week of the drive. "The annual Diabetes Detection and Education Drive can certainly help simplify the problems of control of the disease," Doctor Kanner pointed out and added, "we will have a most successful drive if each doctor of medicine gives his full cooperation."

Dr. Turner Named New Director Of Local Health Services

Dillard D. Turner, M.D., Hazard, was named in August as the new director of Local Health for the Kentucky State Department of Health, according to an announcement by Russell E. Teague, M.D., commissioner of health.

Doctor Turner, former medical director of the Hazard Regional Health Office for the Department, who has also been in private practice for a number of years, succeeds the late E. M. Thompson, who died in June. Doctor Turner will serve as advisor and consultant for Kentucky's 120 county health departments, as well as the regional offices at Hazard and Somerset.

He has had 15 years public health experience in Eastern and Western Kentucky. He is a graduate of Berea College and received his medical degree from the University of Louisville in 1934. He also holds a master's degree in public health from Johns Hopkins University.

Ky. Diabetes Assn. Meeting Set Sept. 20 in Louisville

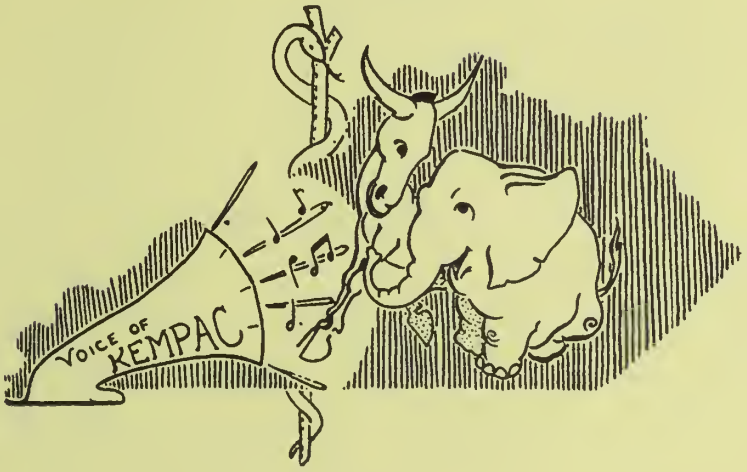
The Kentucky Diabetes Association has scheduled its fourth annual scientific meeting for September 20 in Louisville, to coincide with the start of the KMA Annual Meeting, according to William Winternitz, M.D., Lexington, program chairman for KDA.

The meeting, to be held at the Kentucky Hotel beginning at 10:00 a.m. Monday morning, will feature as guest speakers two well-known Ohioans, George J. Hamwi, M.D., Columbus, and O. Peter Schumacher, M.D., Cleveland. Among the topics under discussion will be genetics, vascular disease, and dietary management, all in their relationship to diabetes.

Doctor Hamwi, professor of medicine and chief of the section of endocrinology at Ohio State, was a guest speaker last year at the KMA Annual Meeting. Doctor Schumacher is on the staff of the division of medicine at Cleveland Clinic.

Other members of the faculty for the session are James R. Hendon, M.D., Louisville, president of the Diabetes Association; C. Charlton Mabry, M.D., Lexington; and G. Randolph Schrodt, M.D., Louisville. All KMA members are urged to attend this important meeting.

We're Broadcasting the News—



of

The Third Annual

KEMPAC Political Seminar

Monday Evening, September 20

Flag Room, Kentucky Hotel

(held in conjunction with the KMA Annual Meeting)

Featuring Outstanding Guest Speakers

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- Senator Peter Dominick (R) of Colorado
- Senator Ralph Yarborough (D) of Texas

Reception and Social Hour at 6 — Followed by Dinner at 7

($7.50 includes pre-dinner refreshments)

YOU will want to attend! — **Make Your reservations NOW!***

*see next page

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Remember

An important congressional election is coming up in 1966. Make your voice heard. Plan now to join KEMPAC. Visit the KEMPAC booth at the KMA Annual Meeting for important membership information! Tickets to the seminar will be available on Monday, September 20, at the House of Delegates meeting and at a booth at the Kentucky Hotel.



An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

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(meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

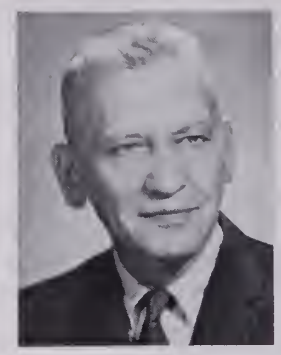
Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

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Mr. Oehlschlaeger



Mr. Lichtefeld

KPA Elects J. H. Oehlschlaeger, R. J. Lichtefeld to Offices

The Kentucky Pharmaceutical Association elected John H. Oehlschlaeger, Paducah, as its president for 1965-66, and Robert J. Lichtefeld, Frankfort, as secretary, during its July 26-28 meeting in Owensboro.

Mr. Oehlschlaeger, a past president of the Paducah Chamber of Commerce, has been in the drug business in that city since his graduation from Tulane University School of Pharmacy in 1929. He is a director of the Citizen's Bank and Trust Company and chairman of the Lourdes Hospital Advisory Board. He is a veteran of World War II and now holds the rank of Commander in the Naval Ready Reserve.

Mr. Lichtefeld, who was elected to fill the vacancy created by the death of E. M. Josey in June, was state drug inspector with the Food and Drug division of the Kentucky State Department of Health before accepting his current position. He is a 1953 graduate of the University of Kentucky College of Pharmacy, and was awarded his master's degree in public health from the University of California in 1959.

In other action at the meeting, Mr. Josey was posthumously named "pharmacist of the year" by the more than 300 pharmacists attending the meeting at Gabe's Motor Inn. The officers were installed at the final session of the meeting on Wednesday, July 28.

KAGP, Industrial Medical Assn. Plan Joint Seminar Oct. 21

Seven guest lecturers, well known in their respective fields of medicine, are scheduled to participate in the Industrial Medicine Seminar October 21 in Louisville, sponsored by the Kentucky Academy of General Practice and the Kentucky Industrial Medical Association in cooperation with Lederle Laboratories.

Carroll L. Witten, M.D., Louisville, KAGP president and Seminar chairman, announced that the program will be held at Stouffer's Louisville Inn.

Among the topics on the day's program are: **"Practical Management of Eye Problems Common to Industry"**, Malcolm A. McCannel, M.D., clinical assistant professor of ophthalmology, University of Minnesota; **"Recognition and Management of Dermatologic Problems"**, Harry M. Robinson, Jr., M.D., head of the division of dermatology at the University of Maryland; and **"Respiratory Diseases Associated with Industry"**, Arthur J. Vorwald, M.D., chairman, department of industrial medicine and hygiene, Wayne State University, Detroit.

Also listed are: **"Soft Tissue Damage"**, Hugh A. Johnson, M.D., plastic and reconstructive surgeon from Rockford, Ill.; **"Skeletal Damage"**, Irvin E. Hendryson, M.D., orthopedic surgeon, Denver, Colo.; and **"Management of the Malingerer"**, Jackson A. Smith, M.D., chairman of the department of psychiatry and neurology, Stritch School of Medicine, Chicago, Ill.

Albert E. Ritt, M.D., St. Paul, Minn., will be the speaker for the luncheon, to which wives are invited. Doctor Ritt is a past president of the American Academy of General Practice.

The program will be followed by a reception for attending physicians and their wives and guests. Entertainment for the wives is being arranged. All physicians are cordially invited to attend.

Dr. Weddle Cited by Boy Scouts

Richard H. Weddle, M.D., Somerset surgeon, was one of six Kentuckians receiving the Award of the Silver Beaver in honor of scouting work, by the Blue Grass Council of the Boy Scouts of American July 24. The award is the highest presented by the council, and reflects outstanding work with youth. Doctor Weddle is also active in medical, church, and civic affairs.

NEWS ITEMS

B. N. Pittenger, M.D., who has been at Paris for over 34 years, has announced that he has retired from practice due to ill health. A 1925 graduate of Indiana University School of Medicine, Doctor Pittenger limited his practice to diseases of the eye, ear, nose and throat. He interned at Lutheran Hospital in Des Moines, Ia., and later took postgraduate training at the University of Rochester, N.Y., the University of Pennsylvania, and at Roanoke, Va.

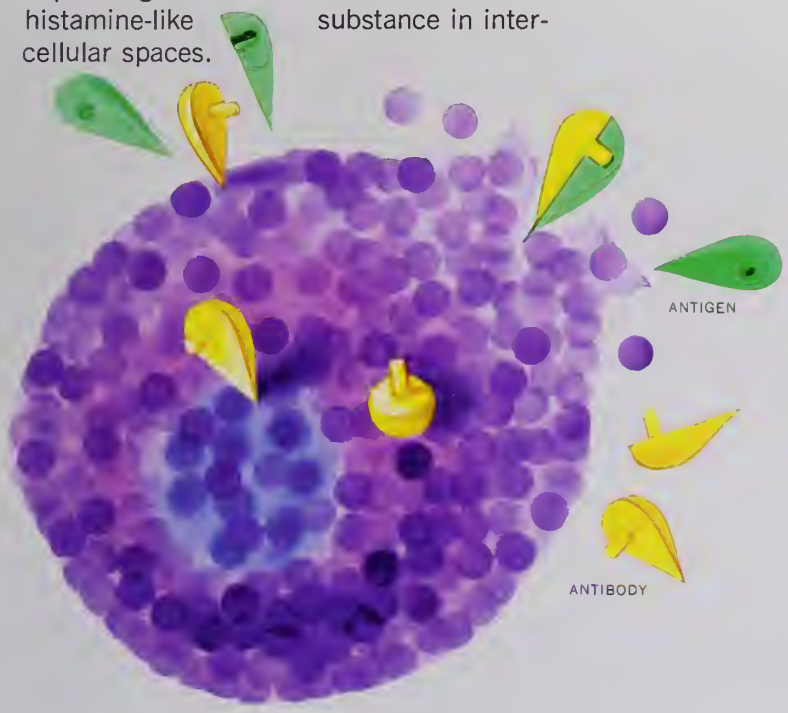
Arthur F. White, M.D., has opened an office in Louisville, where his practice will be limited to allergy. He was graduated in 1956 from Bowman-Gray School of Medicine and interned at Wayne County General Hospital. Following service in the U. S. Navy, Doctor White held a fellowship in allergy at the University of Virginia and completed his residency in internal medicine at the same school.

V. A. Jackson, M.D., has opened an office at Lexington, where he will limit his practice to general surgery. He had practiced at Clinton since 1945. Doctor Jackson graduated in 1941 from the University of Louisville School of Medicine and interned in U. of L. affiliated hospitals.

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in theory, allergy begins like this:

When antigens invade the body, antibodies, formed chiefly by plasma cells, may become attached to mast cells. If the same antigen reappears and reacts with the antibodies, the mast cell disrupts (as pictured below). Subsequently, the "exploding" mast cell deposits granules of bound histamine or histamine-like substance in intercellular spaces.



in allergy, Dimetane® Extentabs®

(brompheniramine maleate, 8 mg. & 12 mg.)

work with no more sedation than placebo*

Although the mechanisms of allergy are still theoretical, the response to Dimetane (brompheniramine maleate) is ample proof that a good antihistamine can, and does, work—and (as reported in one investigation*) with no more sedation than placebo. Dimetane (brompheniramine maleate) assures your allergy patients prompt relief of symptoms while usually permitting them to lead active, alert lives. And a single Extentab provides continuous action for up to 10-12 hours.

*Schiller, I.W. and Lowell, F.C.: New England J. Med. *261*:478, 1959.

BRIEF SUMMARY: *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until response is determined, patient should be cautioned against engaging in mechanical operations requiring alertness. *Side Effects:* Hypersensitivity reactions, including skin rashes, urticaria, hypotension, and thrombocytopenia have been reported rarely. Occasional transitory drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Other dosage forms available:* conventional tablets (4 mg.); Elixir (2 mg./5 cc.); Injectable (10 mg./cc. ampuls, and 100 mg./cc. in 2 cc. vials).

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PHARMACEUTICALS | RESEARCH

basic therapy in low-back pain: bed, board, heat

Whether low-back pain is in the chronic or acute phase, the appropriateness of bed rest for such a patient is beyond controversy. Boards placed under the mattress, for a firmer bed to further immobilize the spine, are another common recommendation. And most investigators consider heat beneficial—moist heat in particular.[1-5]



and Robaxin®-750
(methocarbamol 750 mg.)

(CAPSULE-SHAPED TABLETS)



It has been noted that low-back disorders frequently "...are caused by truly mechanical conditions which yield to conservative treatment."[1] Basic to this conservative treatment are bed rest, a board for the bed, and applied heat. In addition, a good muscle relaxant is often helpful, as "...muscle relaxants are useful in chronic as well as acute low backaches."[4]

Robaxin (methocarbamol) has relieved spasm and pain in cases where the patient "had not responded to conservative measures prior to drug therapy."[6] A 100-patient study showed that Robaxin provided greater relief of muscle spasm for a longer period of time without adverse reactions "than any other commonly used relaxants...."[6]

A well-tolerated[7] skeletal muscle relaxant with "specificity of action,"[7] methocarbamol leaves normal muscle tone unaffected. Moreover, there is little likelihood of sedation[7]—a considerable advantage for the patient who must remain active and alert on his job.

Significantly, clinicians advise using a muscle relaxant "early and in adequate dosage."[8] In this regard, Robaxin (methocarbamol)—*particularly in the 750 mg. dosage (2 tabs. q.i.d.)*—offers optimal therapeutic benefits without a significantly increased incidence of side effects. And just as it works well as part of the basic regimen for low-back pain, so also does Robaxin (methocarbamol) often provide muscle relaxation in such conditions as musculoskeletal injury, chronic neurological disorders, and orthopedic situations.

BRIEF SUMMARY—Robaxin (methocarbamol) Tablets: Contraindicated in hypersensitive patients. Side effects (light-headedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently.

ALSO AVAILABLE: Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)
Robaxisal® (methocarbamol with aspirin) and Robaxisal-PH Tablets (methocarbamol with Phenaphen®).

REFERENCES: 1. Soto-Hall, R.: Med. Sci. *14*:23, 1963. 2. McCarrol, H.R.: Paper read at the Annual Meeting of the American Medical Association, Atlantic City, June 16-20, 1963. See Medical News: J.A.M.A. *185*:39 (July 13), 1963. 3. Gordon, E.J.: Med. World News *5*:54, 1964. 4. Cozen, L.: GP *26*:82, 1962. 5. Larson, C.B.: Postgrad. Med. *26*:142, 1959. 6. Forsyth, H.F.: J.A.M.A. *167*:163, 1958. 7. Weiss, M., and Weiss, S.: J. Amer. Osteopath. Ass. *62*:142, 1962. 8. Rowe, M.L.: J. Occup. Med. *2*:219, 1960.

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News Items

Robert J. Long, M.D., has begun general practice at Berea, where he will be associated with **Earl Hayes, M.D.**, and **Clifford Kirby, M.D.**, Doctor Long was graduated in 1964 from the University of Louisville School of Medicine and interned at St. Elizabeth Hospital, Dayton.

O. M. Patrick, M.D., Frankfort, has become associated with **Dallas C. Hagg, M.D.**, at Frankfort, for the practice of general surgery. A 1958 graduate of the University of Louisville School of Medicine, Doctor Patrick interned at The Medical Center, Columbus, Ga. His residency training was at the Louisville Veteran's Administration Hospital and the Louisiana State University Hospital, New Orleans.

James F. Rice, M.D., has become associated with **Edward M. Haick, M.D.**, at Louisville, where he will practice general medicine. He was awarded his M.D. degree by the University of Louisville School of Medicine in 1964, and interned at St. Joseph Infirmary, Louisville.

James F. Rold, M.D., formerly health officer for Pulaski County, has become associated with **Thornton Bryan, M.D.**, at Cadiz, for general practice. Doctor Rold was graduated in 1963 from the University of Louisville School of Medicine and interned at Lakeland General Hosptial, Lakeland, Fla.

William F. Farrell, M.D., Whitesburg, has begun general practice in that city, where he is associated with the Daniel Boone Clinic. A 1964 graduate of the University of Louisville School of Medicine, he interned at Louisville General Hospital.

Ruth M. Coppedge, M.D., has started general practice at Hopkinsville, where she is associated with **Rachel G. Croft, M.D.** Doctor Coppedge received her medical degree in 1963 from the University of Louisville and interned at St. Thomas Hospital, where she received additional postgraduate training before entering practice.

Lyndon S. Goode, M.D., has opened an office at Hopkinsville, where he will limit his practice to urology. A 1958 graduate of the University of Louisville School of Medicine, Doctor Goode interned at Louisville General Hospital and was a resident there from 1961-65.

Kenneth E. Lanter, M.D., has become associated with **R. C. Smith, M.D.**, at Newport, for the practice of psychiatry. Doctor Lanter was awarded his medical degree by the University of Louisville in 1956, and interned at St. Elizabeth Hospital. He was in general practice at Florence before completing his postgraduate training.

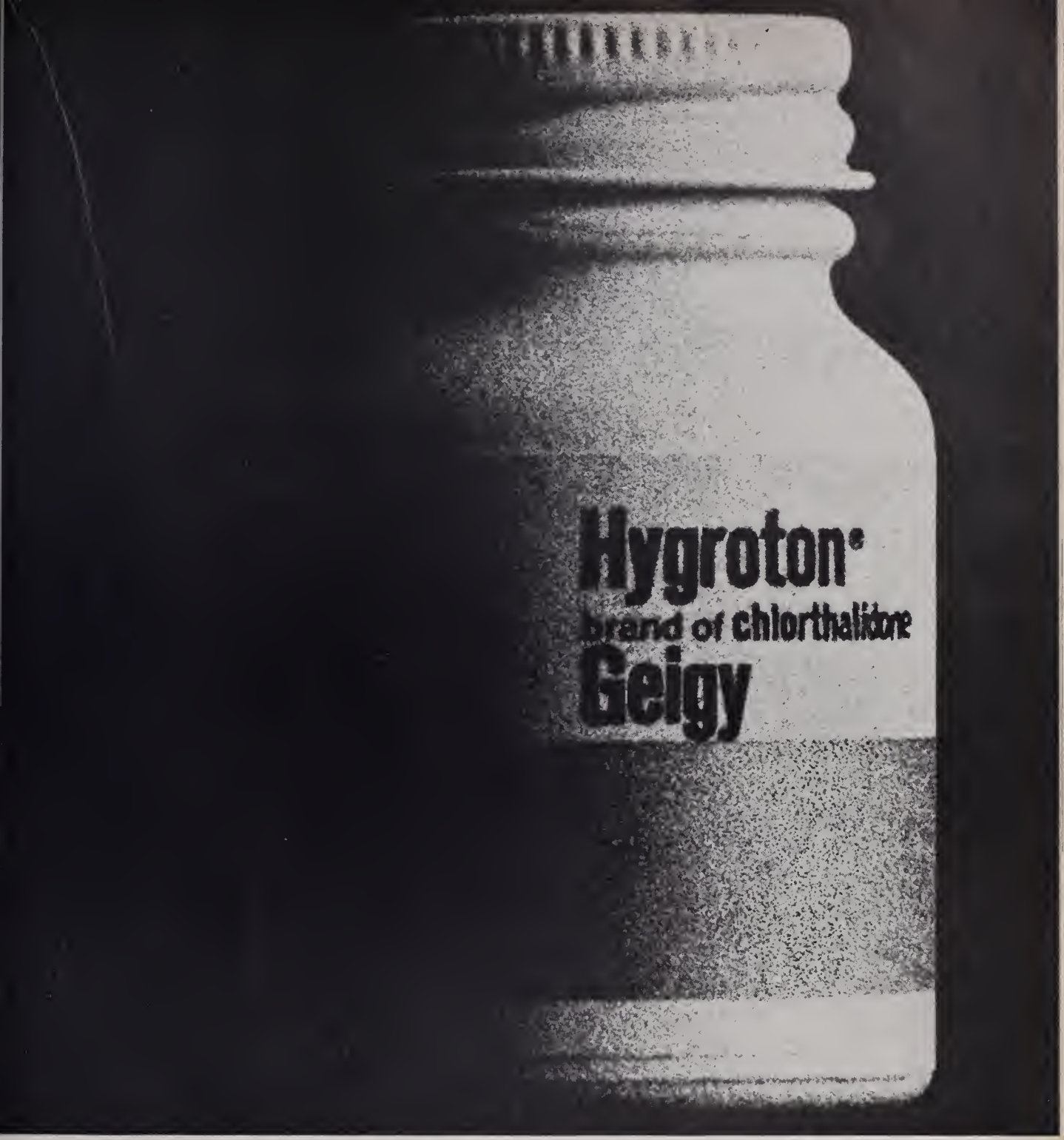
More News Items on Page 720

Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

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Hygroton®
brand of chlorthalidone

The long-acting diuretic



who needs it?

Patients with edema.
Edema in congestive heart failure.
Or in the premenstrual syndrome.
Edema in pregnancy...or obesity.
Patients you want to bring to dry weight.
And those you want to keep at dry weight.
Those you want on single daily doses.
And those requiring even fewer doses.
Those resistant to other therapy.
And those intolerant of other diuretics.
Those who have to pinch pennies.
And those who can afford the best.

NEWS ITEMS

Van R. Jenkins, M.D., a 1962 graduate of the University of Louisville School of Medicine, has begun general practice at Carlisle in association with **Wendell R. Kingsolver, M.D.** Doctor Jenkins completed his internship at the U.S. Naval Hospital in Portsmouth, Va. He was recently discharged from the Navy with the rank of Lieutenant.

Joseph L. Milburn, M.D., who was graduated in 1958 from the University of Tennessee School of Medicine, has become associated with the Trover Clinic at Madisonville for the practice of general surgery. Doctor Milburn interned at John Gaston Hospital, Memphis, and completed his residency in surgery at Kennedy V.A. Hospital, Memphis, this year.

Hilary L. Hunt, M.D., an orthopedist, is now associated with the Fuller-Morgan Hospital, Mayfield. A graduate of St. Louis University School of Medicine in 1958, Doctor Hunt interned at St. Louis City Hospital, and was a resident at St. Louis County Hospital from 1959-60. His residency training was completed at the Campbell Clinic, Memphis, this year. Doctor Hunt was in general practice at Mayfield from 1960-62.

Don C. McFadden, M.D., a 1962 graduate of Duke University School of Medicine, is now in general practice at Mt. Sterling, where he is associated with **Frank K. Sewell, M.D.** Doctor McFadden interned at Cincinnati General Hosptial before serving for two years with the U.S. Air Force.

Norman H. Liebschutz, M.D., Louisville, has opened an office in that city for the practice of pediatrics. Doctor Liebschutz, a 1959 graduate of the University of Louisville School of Medicine and interned at Louisville General Hospital. His residency training was taken at Louisville Children's Hospital and the Children's Medical Center at Dallas, Tex.

J. Patrick Sutherland, M.D., has become associated with **J. B. Marshall, M.D., O. J. Hayes, M.D., and W. H. Powers, M.D.**, in Louisville, and will limit his practice to obstetrics and gynecology. Doctor Sutherland, who was graduated from the University of Louisville School of Medicine in 1958, interned and completed his residency at St. Joseph's Infirmary in Louisville. He recently completed two years of service with the U.S. Air Force.

Robert O. Shoffstall, M.D., has begun the practice of general surgery at Whitesburg, where he is associated with the Daniel Boone Clinic. A 1955 graduate of Hahnemann Medical School, he interned at Harrisburg General Hospital, Harrisburg, Pa., and completed his residency at the University of Pennsylvania.

Craig C. Wetzelberger, M.D., is now practicing in association with **Fred D. Barlow, M.D.**, and **Russell F. Scalf, M.D.**, at Louisville, where he will limit his practice to radiology. Doctor Wetzelberger received his medical degree in 1960 at the University of Louisville School of Medicine and completed both his internship and residency at Louisville General Hospital.

Robert T. Peterson, Jr., M.D., has been elected president of the Fulton Lions Club, according to a recent newspaper report. Doctor Peterson, a general practitioner at Fulton, is a 1959 graduate of the University of Tennessee College of Medicine.

Eugene A. Cooper, M.D., who recently practiced in Warsaw, has become associated with **Robert M. Sirkle, M.D.**, in Lexington, for general practice. Doctor Cooper was graduated in 1952 from Tulane University School of Medicine, and interned at Ft. Sanders Hospital, Knoxville.

Frank W. Lehn, M.D., Louisville, has become associated with **William P. Peak, M.D.**, for the practice of rheumatology. A 1961 graduate of the University of Louisville School of Medicine, he interned at Jackson Memorial Hospital and completed his residency training in internal medicine at Emory University. For the past year he has been a fellow in rheumatology at the University of Alabama.

Licenses Issued to 114 in July

Licenses to practice medicine in Kentucky were issued to 114 physicians in July, according to Mrs. Fred Caudill, director of Medical Licensure for the Kentucky State Board of Health. Some of this number have entered military service or are taking residency training; others have entered private practice.

The alcoholic *CAN* be rehabilitated

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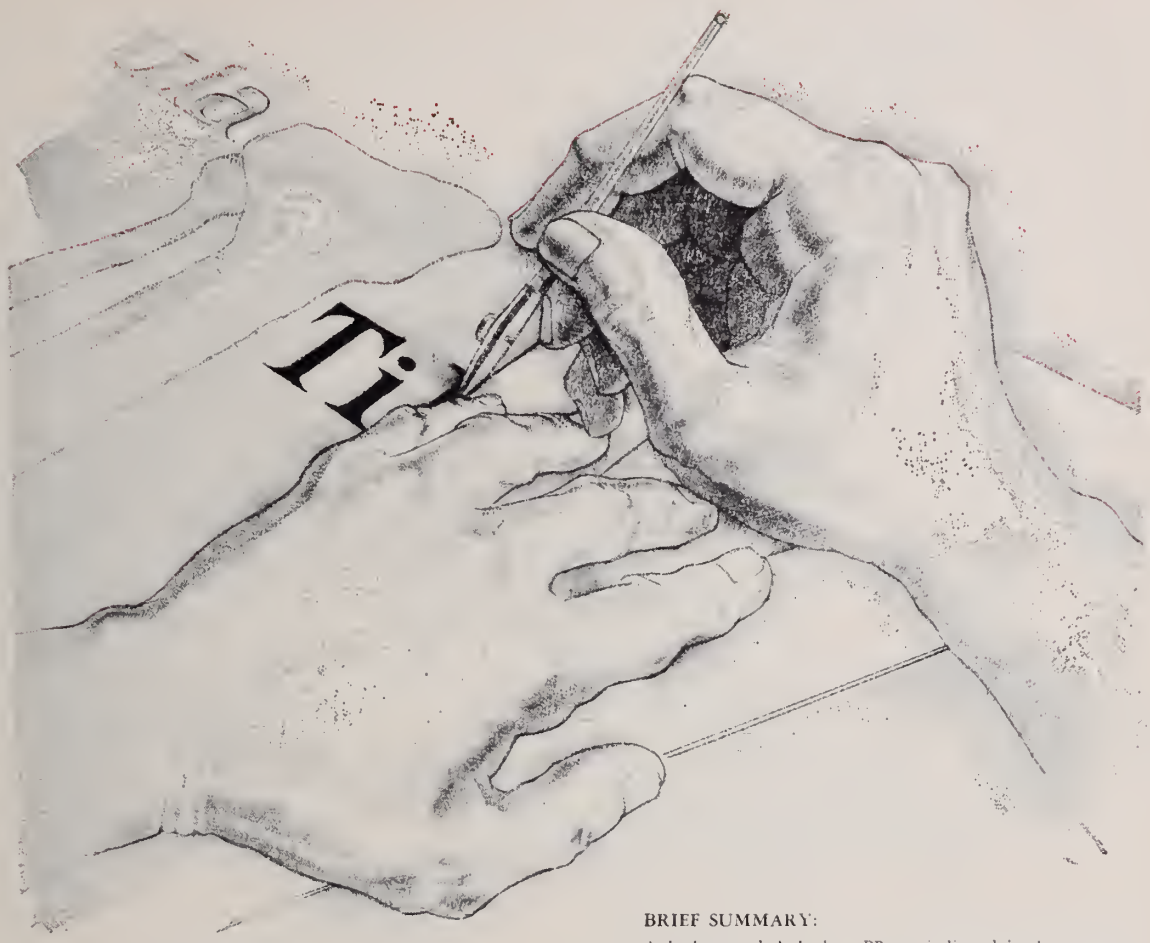
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Because it contains no sodium, Arthralgen is often a safer and more suitable analgesic for use in the long-term treatments of arthritic patients who have other conditions which require sodium restriction.[1]

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(Arthralgen with prednisone 1 mg.)

BRIEF SUMMARY:

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chickenpox or susceptible persons exposed to it.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

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DOSAGE: One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953.

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"Fireside Conferences" Planned For Chest Physicians Session

The Kentucky Chapter of the American College of Chest Physicians and the Kentucky Thoracic Society, co-sponsors of their specialty group meeting on Tuesday afternoon, September 21, will feature on their program a series of "Fireside Conferences", or round-table discussions.

The conferences, an innovation replacing the usual formal dissertations, will be made up of six tables with the following discussion topics: Cardiovascular Disease and Indications for Surgery; ECG and VCG; Allergy; Medical Diseases of the Chest Including Fungous Diseases; Thoracic Surgery; and Pulmonary Function.

Norton Seminar Planned Dec. 16

Robert I. Wise, M.D., Magee professor of medicine and chairman of the department at Jefferson Medical College, will be the guest speaker at the annual Norton Memorial Infirmary Seminar in Louisville December 17, according to Robert Lich, Jr., M.D., Seminar chairman.

The theme of the program will be "Simplification of medical and surgical Diagnosis". A number of local speakers will also participate. Doctor Wise's topics will be "The Selection of Therapy in Bacterial Infections", and "Medical Rounds in Northeast Brazil". The latter is composed of commentary on a collection of color slides, reported to be of great interest. All Kentucky physicians are urged to plan ahead to attend this meeting. Further information will appear in The Journal next month.

Aid Training Survey Conducted

The KMA Disaster Medical Care Committee and the Kentucky Hospital Association are conducting a survey of Kentucky hospitals in a cooperative effort to determine the extent of ambulance driver training in first aid procedures.

The form contains questions concerning emergencies which are professional in nature. Members of the Disaster Medical Care Committeee urge hospital chiefs of staff to assist hospital administrators in completing the questionnaire which is being distributed by KHA.

GENERAL PRACTICE FOR SALE: Western Central Kentucky Population area of 5000. Good industrial growth potential. Modern hospital in county. Entering residency. Will introduce new man and work with him for suitable time. Includes office building with or without full line of modern equipment. Reply Box C-25, Journal of the Kentucky Medical Association.

KMA Council And Committee Reports

Council on Legislative Activities

John C. Quartermous, M.D., Murray, Chairman, National Affairs; James C. Cantrill, M.D., Georgetown, Chairman State Affairs

KMA Headquarters Office **Wednesday, July 21, 1965**

The KMA Council on Legislative Activities met on July 21, 1965. The Council gave careful consideration to revising the Key Man Booklet, changing the nomenclature, and making this handy reference for legislative key men more effective. This will be perfected in subsequent meetings of the Council.

The Council also gave further consideration to the upgrading of the Nurse Practice Act; medical licensure; animal research; the Heart, Cancer and Stroke Bill; the Medicare program; and the continuing development of the legislative program. In due course, the Council will make, as provided by the Bylaws of KMA, specific recommendations to the Board of Trustees on all of these legislative proposals as they are introduced, and recommend policy.

The Council reaffirmed its beliefs in the objectives of KEMPAC and AMPAC. The final reports of the National Affairs chairman and the State Affairs chairman to the House of Delegates were approved.



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when a change in environment overwhelms him with anxiety

Failing health, financial difficulties, or the death of a spouse are among the reasons why elderly people may be obliged to leave their familiar surroundings. Moving in with children or entering a home for the aged may satisfy practical requirements but can be psychologically traumatic since emotional resilience tends to diminish with age.

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Digest of Proceedings KMA Board of Trustees

August 4 and 5, 1965

The Board of Trustees met August 4 and 5 primarily for the purpose of considering the reports of the councils and standing committees to the House of Delegates. The KMA Bylaws provide that the Board shall meet and review the reports to the House of Delegates that the councils and standing committees make.

The chairman of the Board, Robert E. Pennington, M.D., asks that this opportunity be taken to express appreciation to the chairmen of the councils and committees who attended this lengthy meeting and for their cooperation.

In addition to these matters, the Board of Trustees handled a number of recommendations from councils and committees, discussed in detail the multi-county regional health center in the forty-county Eastern Kentucky area, and decided on nominations to make to the House of Delegates for membership on the Judicial Council.

Careful consideration was given to the special operation of Public Law 89-97 (amendments to the Social Security Act in 1965). A special ad hoc committee was named to study this matter and advise the Board.

The schedule for the three meetings of the Board of Trustees held during the Annual Meeting was set.

New Rehabilitation Center Open

The Louisville Rehabilitation Center moved into its new quarters just east of Jewish Hospital in the medical center complex early last month. For the past several years the Center has been housed in a building on East Madison, leased from General Hospital.

Formerly able to accommodate only 18 patients, the Center can now handle 30 inpatients on the top floor. The first floor contains offices, electrotherapy and hydrotherapy rooms, and a large gymnasium. The $1.2 million Center, built with the help of federal funds, is an independent and self-supporting institution, cooperating with a number of public and private agencies in the treatment of the handicapped.

Medical Assistants Workshop Set

An educational workshop for medical assistants has been scheduled for Bowling Green on October 3 by the Kentucky State Association of Medical Assistants, according to Mrs. Wanda Taylor, Louisville, KSAMA president.

The workshop is planned for medical assistants in five counties in the area. For information, contact Mrs. Taylor, in care of Robert G. Cooper, M.D., Heyburn Building, Louisville; or Miss Dorothy Downs, in care of Jack L. Chumley, M.D., Heyburn Building, Louisville.

KMA Announces New Members

Five physicians have become new members of the Kentucky Medical Association, according to August 20 KMA membership department records. The five are listed as:

Darran N. Huggins, M.D., Providence; Frank W. Oliphant, M.D., Cadiz; and David L. Brown, M.D., Glenn S. Hooper, M.D., and Kenneth N. Walton,

ACP Course to be Held at U. of K.

The American College of Physicians will sponsor 19 postgraduate courses during the coming academic year. One of the courses, "Pathophysiological Basis of Therapeutics" will be held at the University of Kentucky Medical Center November 15-19.

For a complete list of the planned courses and for other information, write to Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia.

COUNTY SOCIETY REPORTS

Mason

John T. Teegen, M.D., Maysville, took office in July as president of the Mason County Medical Society for the coming year. H. N. Parker, M.D., Maysville, will serve as secretary.

Muhlenberg

The August 2 meeting of the Muhlenberg County Medical Society was the Society's Annual Conference on Communications. Mr. Larry Stone, president-elect of the Kentucky Press Association, spoke on "The American Presidency 1828-1965; a Critical review".

In the workshop period following the banquet, representatives of three newspapers and two radio stations reviewed policies and practices of their media with reference to medical and health news. Plans were made to facilitate release of medical information concerning accident victims, with co-ordination of the notification of the next-of-kin.

Welch Memorial Award Announced

The Annual Norman A. Welch Memorial Award, named in honor of the late AMA president, will be presented for the first time this year by the National Association of Blue Shield Plans to the author of the most scholarly and meritorious contribution to the literature of medical economics. The work should have been published or presented between July 1, 1964 and June 30, 1965. For additional information, write the National Association of Blue Shield Plans, 425 N. Michigan Ave., Chicago, Ill., 60611.

Syphilis and Seroreactivity

(Continued from Page 687)

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Pica and Anemia

(Continued from Page 693)

several factors. The hemoglobin level of Lanzkowsky's patients was much lower than in Gutelius' group. Complex psychological and environmental factors make comparison of the two series difficult. It is imperative that every physician when faced with a problem of a child with pica should do a complete blood count. Correction of anemia should be carried out if present, and close follow-up should be conducted to rule out the infrequent case of anemia as the result of blood loss and not that of nutritional factors.

Summary

A case of pica and anemia has been presented. The importance of a thorough search for the cause of anemia needs emphasizing.

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The manufacturer of a drug has a special mission in life if his goal is progress and growth and public contribution. He must depend on research even more than promotion if he is to achieve this goal and hold it. For without this exploring of the unknown he can be certain that to mark time is an act designed for those who are suicidally minded businesswise. His is a trust shared by the professional man looking for new ways to heal ailing bodies, by those on whose bodies the healing will occur, and by the investing public as it puts to work its available cash to help this part of our life grow.—Austin Smith, M.D., in *Experimental Medicine and Surgery,* 22: 2-3, (June-Sept.) 1964.



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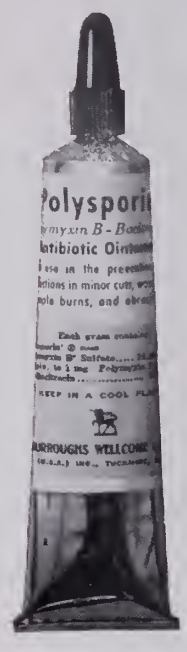
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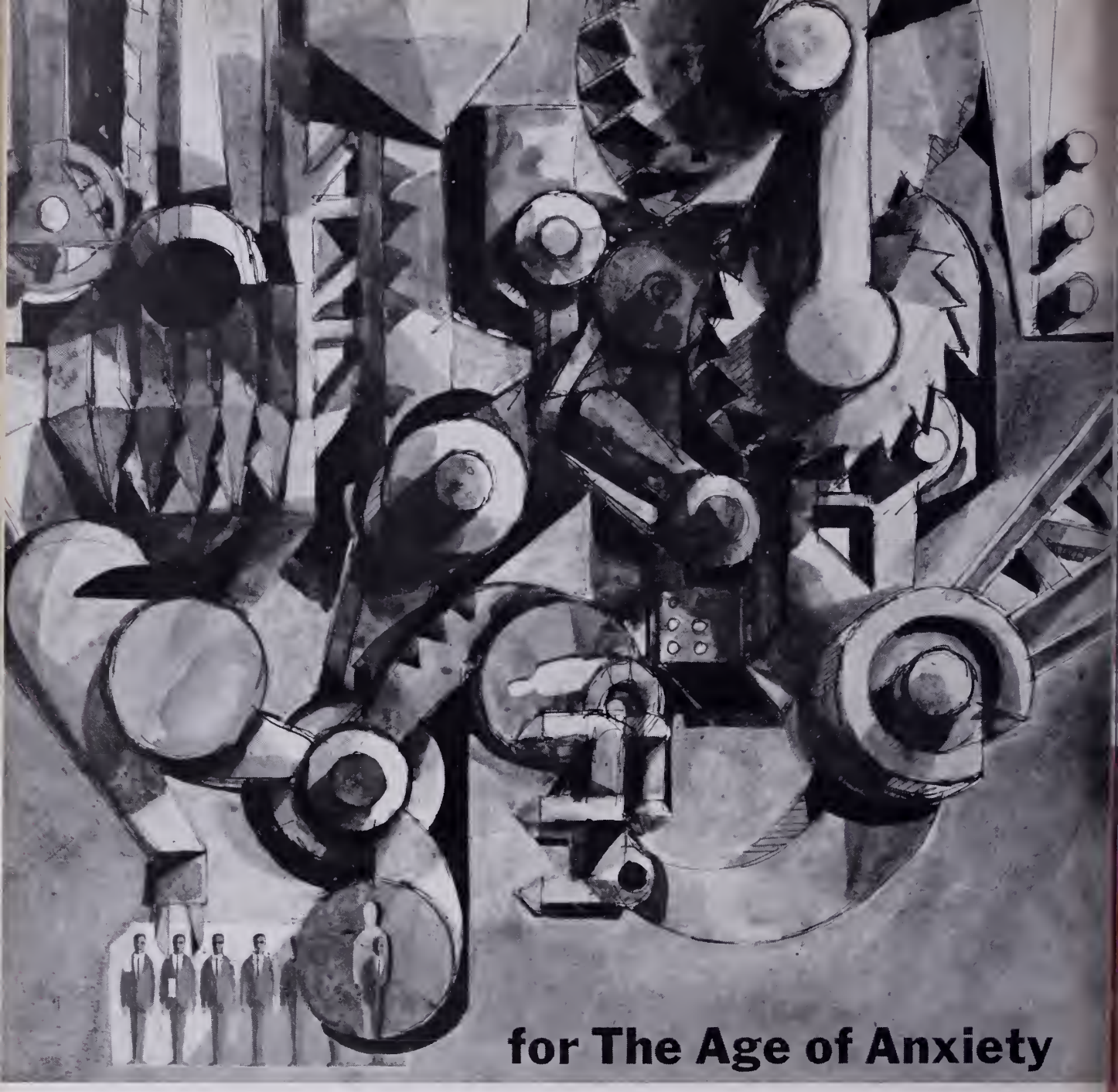
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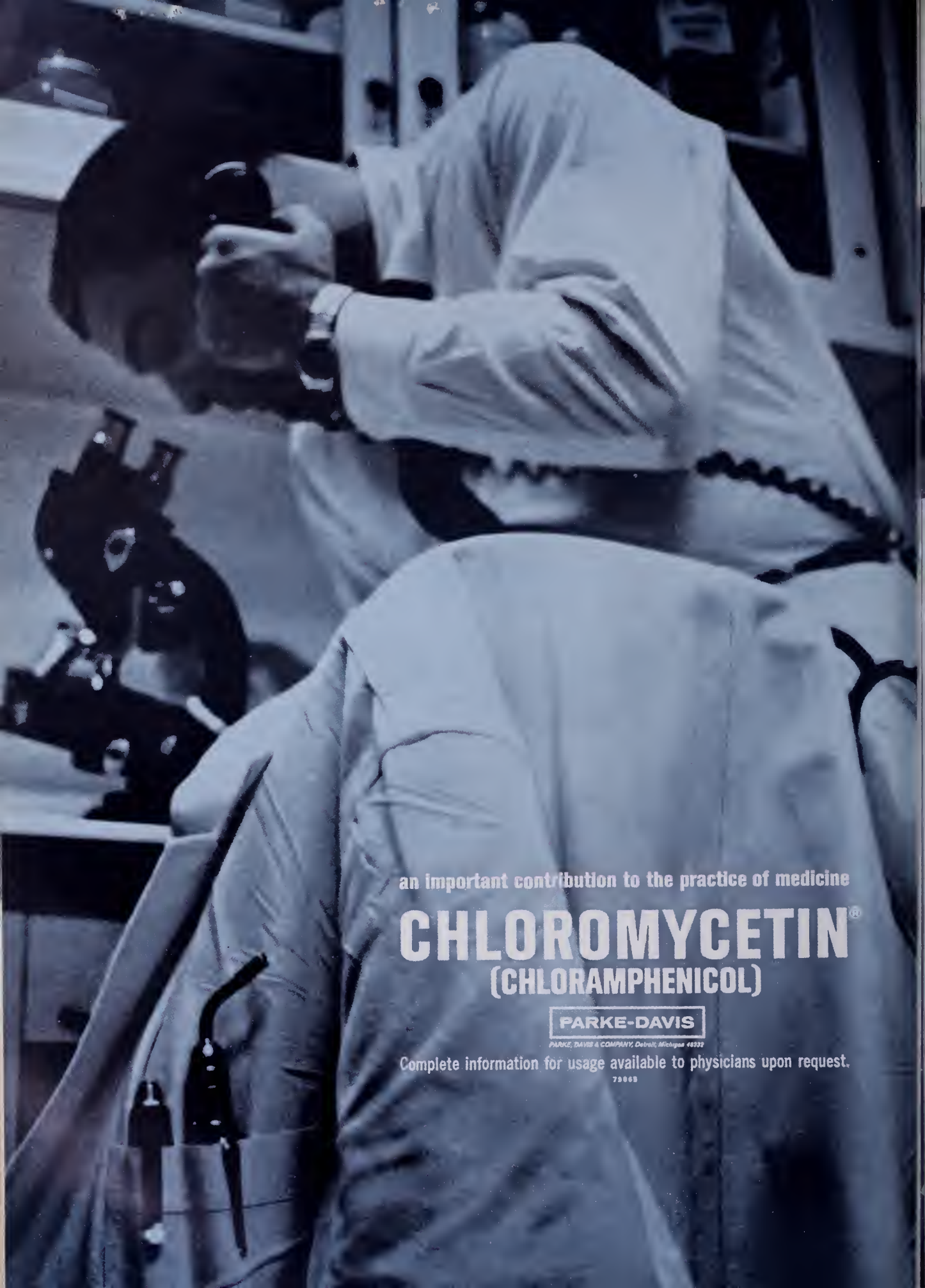
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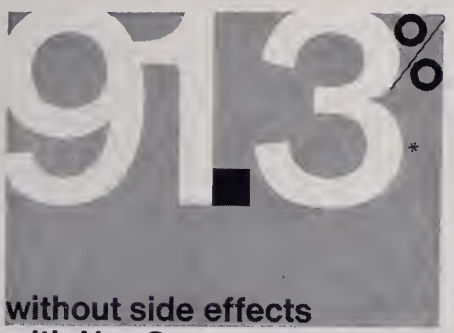
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Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

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How supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1,000. **250 mg. for children,** available in bottles of 56 and 1,000.

References: (1) Carroll, G.: Urologists' Letter Club, June 1, 1964. (2) McDonald, D. F., and Short, H. B.: Address to the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, Oct. 26-28, 1964.

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MESSAGE FROM THE PRESIDENT



Our Responsibility

LET'S get medicine and the physicians out of politics and back to the laboratory, hospital and sick room. This was a suggestion made by a physician after hearing discussions of various bills.

In the first place no one can divorce himself from the political arena if he is to maintain his status as a good citizen. A knowledge of the candidates, the philosophies of each and legislation contemplated is evidence of good citizenship.

In the second place the physician must be available at all times to study and discuss all measures that would affect the health and welfare of the patient. He is the one most qualified to guide legislators away from pitfalls as far as Medical Care is concerned.

Some may say that our advice is not always sought or followed and this is true, but discouragement or withdrawal would be a reversal in medical tradition. It would stamp our era as lacking in courage and vision. May this not be true.

The great pioneers in medicine spent their time in study and research. They served well as individuals. With the social trends and vote-getting legislation of our day, our patients need us and our help in another dimension.

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Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage
Initially, give 400 mg. daily (one tablet or capsule q.i.d.), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. To minimize gastric distress, Butazolidin alka capsules may be the preferred form.

Note: The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

Butazolidin alka

Each capsule contains:	
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dried aluminum hydroxide gel	100 mg.
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"...it is extremely difficult and sometimes impossible to differentiate between 'pure depression' and anxiety and it is questionable whether depression without a certain degree of anxiety really exists."

Lehmann, H. E., Canad. Psychiat. Assn. J. *4(S)*: 1-12, 1959



An antidepressant designed for the clinical realities of office practice

As many physicians have reported, the large majority of neurotic depressed patients suffer from both depression and anxiety. It may be difficult to decide whether these patients are primarily depressed or primarily anxious. And yet drug treatment of only the symptom which seems more prominent may exacerbate the untreated element of the depression complex.

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Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

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THE INSURANCE PAGE



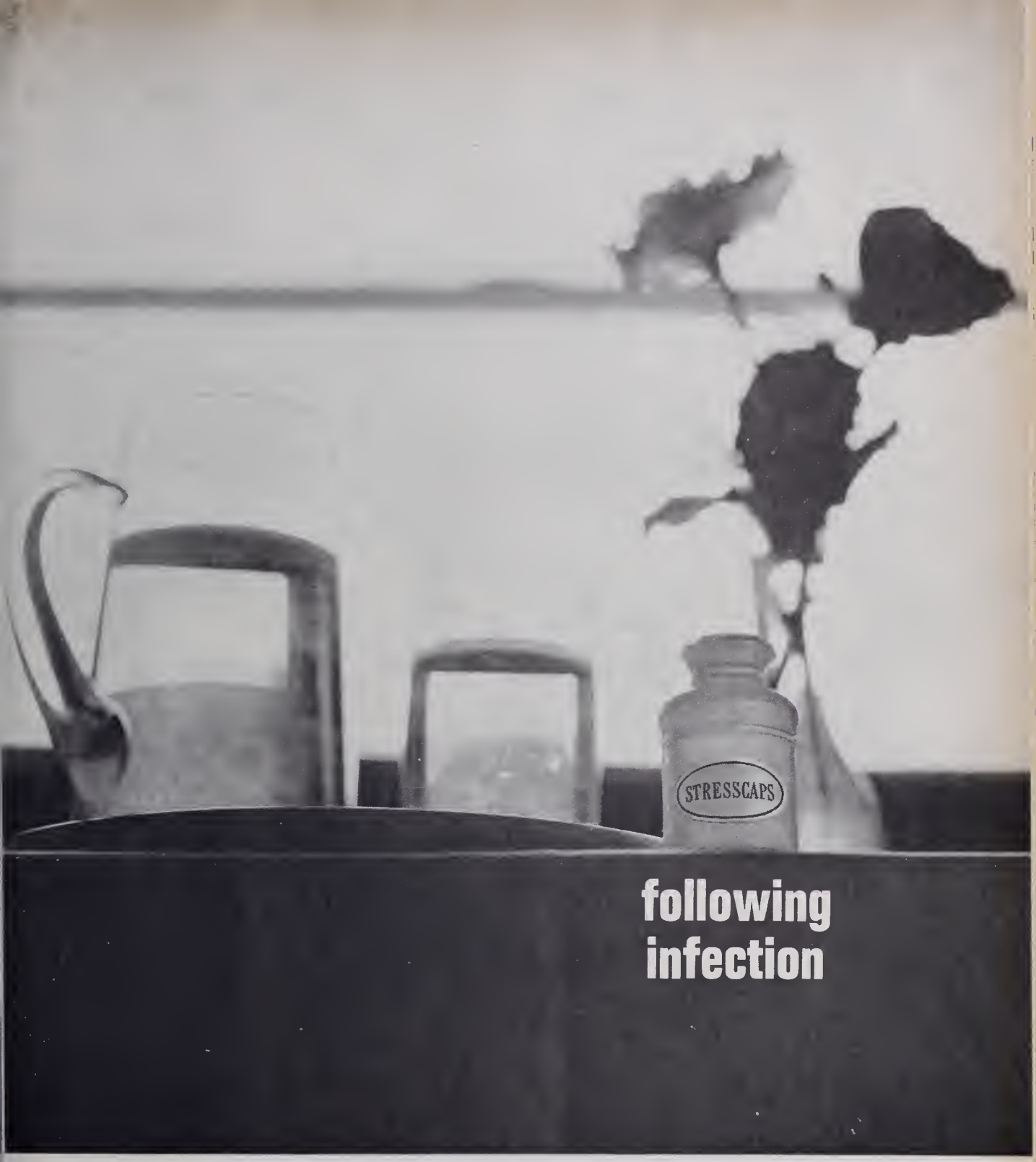
Why Insurance Review Committees?

ORGANIZED medicine has long been concerned with the institution and enforcement of rules and ethical principles applying to the practice of medicine. Although experience indicates that the number of disciplinary cases is small, there is increasing public interest in the subject of medical self-discipline. A similar degree of public interest exhibits itself in connection with physician responsibility for "control" of certain medical care costs.

There have always been mechanisms available at the county and state levels for the handling of complaints against physicians. However, the insurance companies and pre-payment plans have hesitated to forward claims to such committees because their cases usually do not involve "complaints", but rather requests for advice and guidance. They fear that to turn to a grievance committee for advice might defeat the very reason for submitting the case, that is, to bring about better cooperation and understanding between the medical profession and the various prepayment plans. The fundamental advantage of a review committee over the grievance committee is that such a committee is known as an advisory mechanism without the implication of disciplinary action.

The practice of medicine is a privilege and as such must be guarded and protected from those within the profession who will not practice in the best interests of the public, and from those without who would have the system of private practice changed to the detriment of the public and the profession. Now, more than ever before, it is abundantly clear that the survival of our system of private medical practice depends, in a large measure, on the success or failure of voluntary health insurance. The proliferation of insurance review committees, hospital utilization committees, Blue Shield committees, and other groups with differing names but similar purposes, is testimony to the medical profession's awareness of its obligations in this field.

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INDICATIONS:
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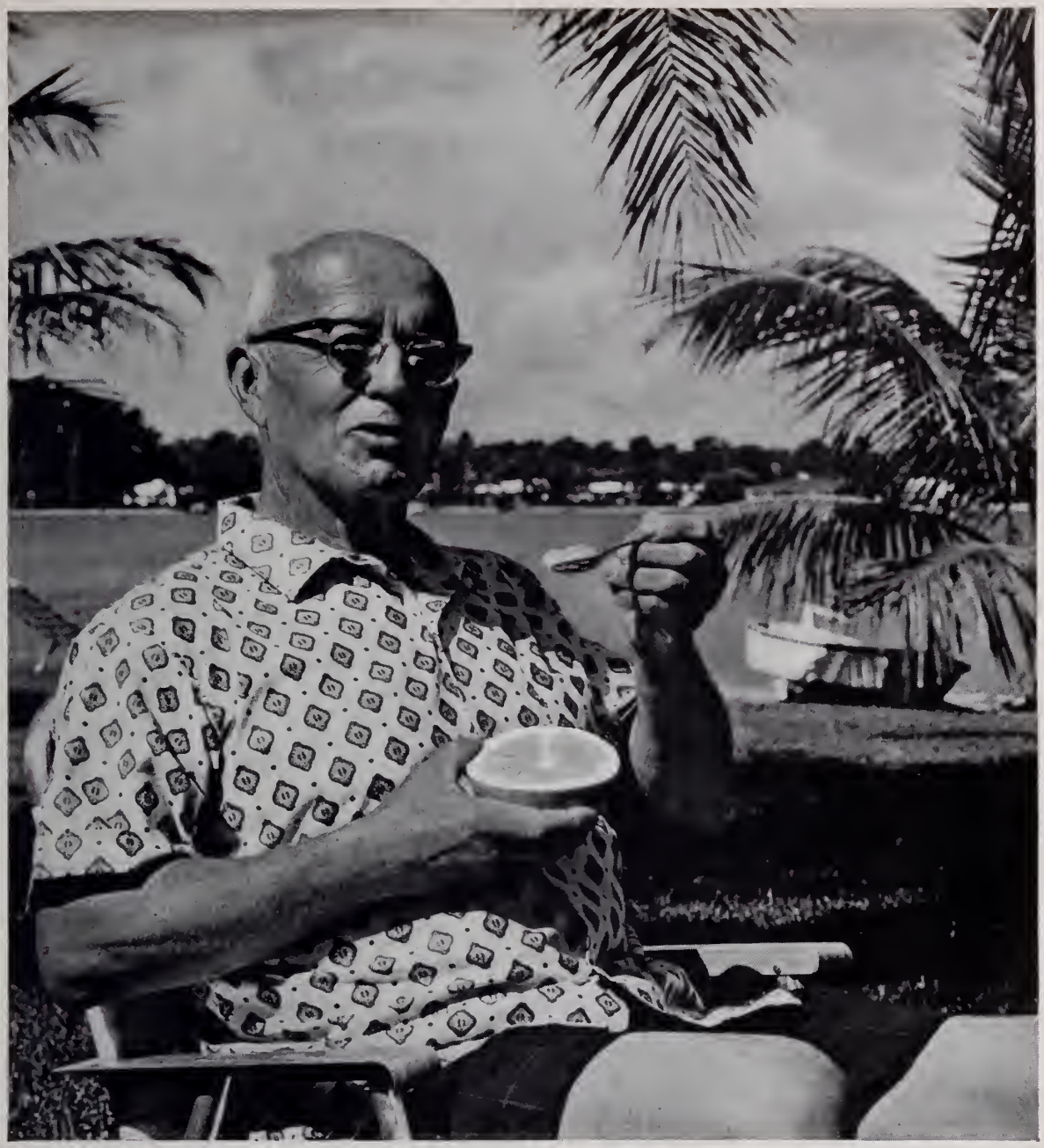
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From the files of the COMMITTEE FOR THE STUDY OF MATERNAL MORTALITY



CASE #11-64. A 34 year old, divorced, white, gravida 7, para 4, developed an ache in her shoulders on March 28, 1964. She refilled a prescription for an antibiotic she had previously received and began to take this on her own. She felt better on the following day, March 29, but the shoulder ache recurred, as well as chest pain and chills that night. She experienced a hard shaking chill on March 30 and was admitted to the hospital. Her menses were due but had not yet started. The past history was non-contributory.

On physical examination she was in mild distress. The temperature was 100°, the blood pressure was 112/76 and the pulse 88. The heart and lungs were normal to percussion and auscultation and no murmurs were heard. There were no palpable abdominal masses, although there was vague tenderness to palpation just above the symphysis. Hyperactive bowel sounds were present, but there was no complaint of cramping pain. Pelvic examination was not done because the patient had just begun to menstruate. The flow was described as heavy and dark. The working diagnosis was acute gastroenteritis. A plain film of the chest appeared normal. A portable postero-anterior film of the abdomen showed no evident abnormality in the bowel pattern.

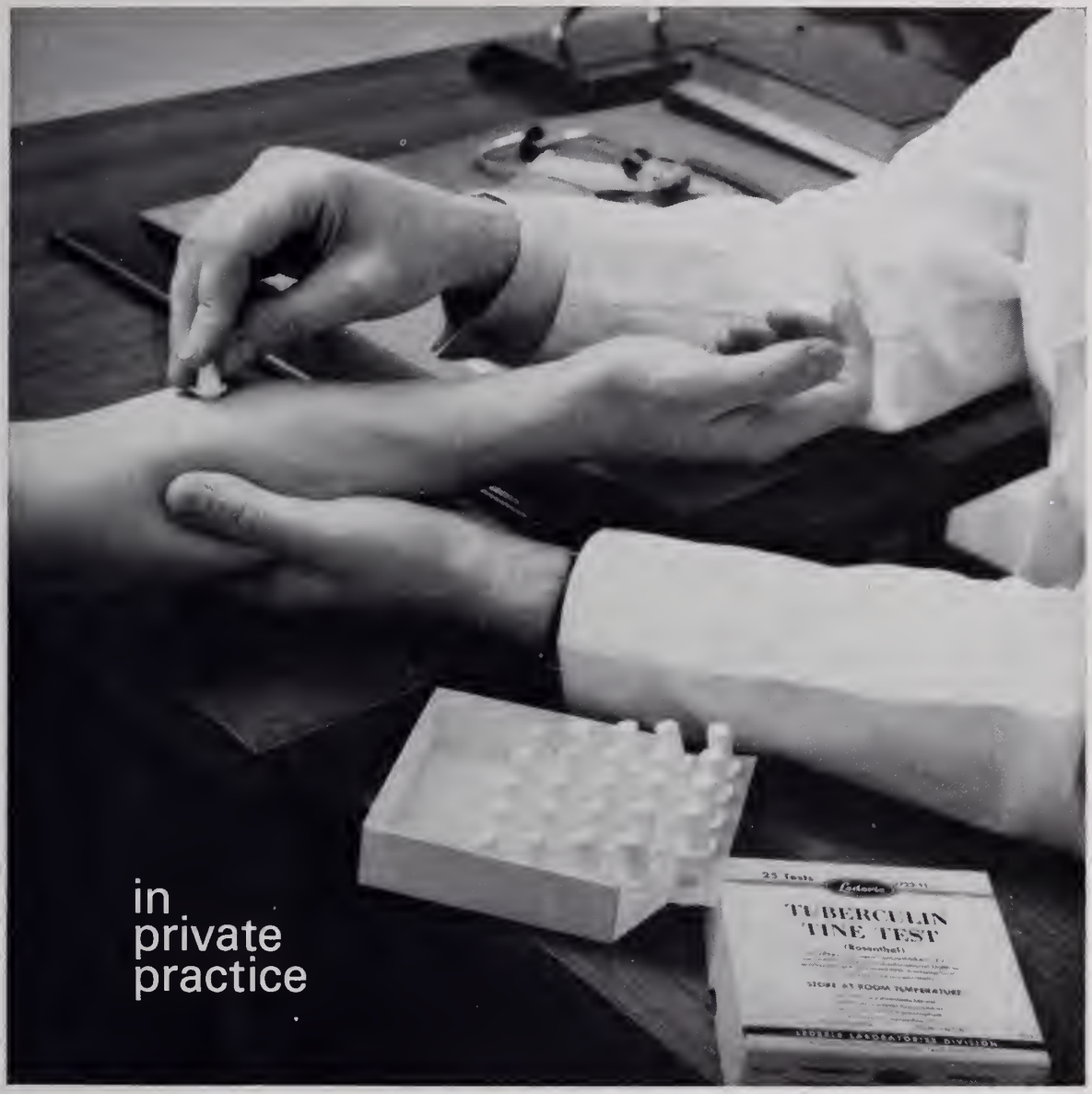
The patient had approximately five loose, watery bowel movements on the day of admission. Her temperature was 100.4° a few hours after admission. This fever promptly responded to an intramuscular injection of Paralgin. In the early morning hours of March 31, the patient awakened with backache which was promptly relieved by APC. At approximately 4:30 a.m., she called for a nurse and complained that she was turning purple. She had cyanosis of the hands and lips with some blotchiness on the hands, the lips, and the bridge of the nose. The blood pressure was unobtainable.

A consultant saw the patient and obtained the following additional history from the family. She had been well until one week before admission when she complained of generalized abdominal pain, which caused her to bend forward. The pain became progressively worse, and for 4 days she was forced to spend much time in bed. Members of the family noticed that she had intermittent periods of unconsciousness during which she could not be aroused. She would regain consciousness periodically and again be able to be up and around. She had some vomiting two days before admission. Examination by the consultant showed the blood pressure to be 0/0 initially; this was promptly restablished to a level of 80 systolic with Levophed. The patient appeared pale and critically ill; her hands and feet were cold to the touch, and she was only moderately responsive. The heart rate was regular at 140/minute, and the lungs were clear. There was muscle guarding with definite resistance to palpation over the lower abdomen. The patient complained of rather severe, diffuse abdominal tenderness. The percussion note was tympanitic and no peristalsis was heard. There was marked tenderness on manipulation of the cervix. The consultant's diagnosis was acute circulatory collapse probably produced by severe toxemia and bacteremia, and acute pelvic inflammatory disease with peritonitis. An intravenous fluid infusion containing chloromycetin, Solu Medrol, and Neosynephrine was started. A second consultant saw the patient at 8:15 a.m. on March 31 and expressed the opinion that the patient had fulminating septicemia. The initial blood count was 8,200 with 95 per cent polymorphonuclear leukocytes and 5 per cent lymphocytes. Repeat count on March 31 showed a white blood count of 25,000 with a differential still markedly shifted to the left. Blood cultures were taken as a means of determining if this represented a viral or a bacterial infection. The blood pressure was maintained with Levophed and Neosynephrine, oxygen was administered through a nasal catheter, and intravenous antibiotics and steroids were given. In spite of these measures, the patient died at 10:40 p.m. on March 31, 1964.

An autopsy limited to the abdomen was permitted. There was moderate distention of the small and large bowel with a localized area of purulent peritonitis involving primarily the pelvic area. The uterus was slightly anteflexed, and somewhat enlarged and soft. On the superior surface of the uterus in the mid portion of the fundus there was a perforation approximately 3 millimeters in diameter with a small area of hemorrhage surrounding the perforated area. One centimeter to the left of the lateral margin of this perforation there was a second area of ecchymosis with some localized thinning of the uterine musculature. When the uterus was opened, a moderate amount of foul-smelling necrotic tissue was encountered and a sinus tract through the musculature of the uterus in the area of the previously described perforation was demonstrated. The endocervical canal contained a small amount of clotted blood. The provisional anatomical diagnoses were: septicemia; Waterhouse-Friderichsen syndrome (bilateral hemorrhage of adrenals); acute endometritis; perforation of the uterus; focal peritonitis; renal ischemia; and septic splenitis.

Microscopic examination of the uterus supported the diagnosis of acute endometritis with perforation of the uterus and also showed fragments of necrotic decidual tissue. The pathologist ascribed the death to massive septicemia with acute adrenal failure following perforation of the uterus and acute endometritis.

(Continued on Page 812)



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Contraindications: Pregnancy; leukemia, lymphoma and other generalized malignancies; brain damage in children under one year of age; febrile illness; allergy to egg proteins, neomycin, or streptomycin. Precautions: Use cautiously in patients with a history of tuberculosis and patients being treated with steroids, irradiation, alkylating agents, and antimetabolites. Consult package literature before administering Lirugen.

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References: 1. Goldsmith, J. W.: Minn. Med. (Feb.) 1957. 2. Groskloss, H. H., Clancy, C. L., Healey, E. F., McCann, W. J., Maloney, F. D., Loritz, A. F.: Clinical Medicine (Sept.) 1955. 3. Codling, J. W., Lowden, R. J.: Northwest Med. (March) 1958. 4. Bethea, R. C.: International Record of Med. (May) 1960. 5. Lenz, W., Second International Conference on Congenital Malformations, N. Y., N. Y., (July) 1963.

Side effects: the incidence of drowsiness and other atropine-like effects is low. However, caution patients engaged in activities where alertness is mandatory.

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†The need for these substances in human nutrition has not been established.

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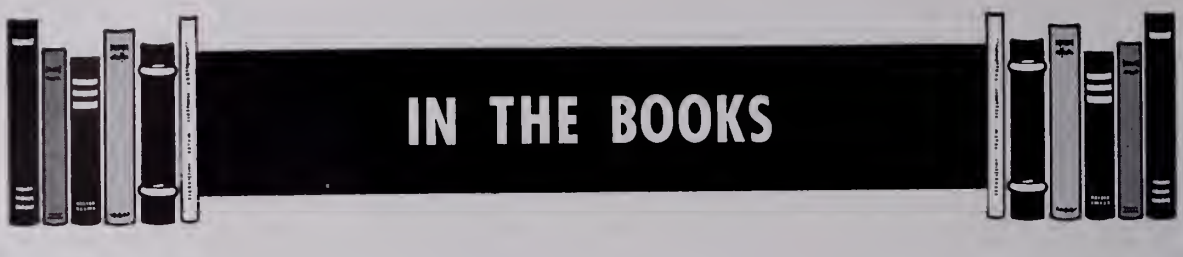
Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

Side Effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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RHEUMATIC FEVER — DIAGNOSIS, MANAGEMENT AND PREVENTION: by Milton Markowitz, M.D., and Ann G. Kuttner, M.D.; Published by W. B. Saunders Company, Philadelphia, and London, 1965; 242 Pages; Price, $7.50

This is a very good compilation of most of the current useful information on rheumatic fever in children. All aspects are covered from the biology of the streptococcus to the details of clinical manifestations and management. The authors are experienced clinicians and investigators who have contributed ably to this field themselves.

There is little to criticize. While much of the material can be obtained from current texts and monographs few have the time to do so or to select as wisely as the authors. The weakest portions are those dealing with chronic rheumatic heart disease. The details of cardiac diagnosis are too sketchy for the present state of knowledge. Such an important complication as bacterial endocarditis is relegated to one inadequate paragraph. The variations in the clinical picture in older patients are not touched upon and surgical treatment is discussed only obliquely.

The chapters on the streptococcus, epidemiology and treatment are especially well handled. The final chapter on community health services by Leon Gordis is welcome. The literature citations are current and complete. The bibliography will be most useful. Several appendices are provided covering such things as the Jones diagnostic criteria, details of prevention of rheumatic fever and bacterial endocarditis and methods for culturing the streptococcus.

This is a useful book for the general practitioner and general pediatrician. The cardiologist will find it sufficient for his needs. The internist will be disappointed by the absence of consideration of the more variable manifestations of rheumatic fever and rheumatic heart disease in the adolescent and adult.

E. D. Pellegrino. M.D.

TEXTBOOK OF OBSTETRICS: by John C. Ullery, M.D., and Zeph J. R. Hollenbeck, M.D.; Published by the V.C. Mosby Company, St. Louis, 1965; 729 Pages; Price, $17.50

The aim of this textbook, as stated in the preface, is to "offer concise but adequate presentation of the proper management of the pregnant patient from conception through involution". Doctors Ullery and Hollenbeck are joined by thirty-one contributors from The Ohio State University College of Medicine. They have accomplished their goal with a succinct and timely book.

Practically the entire field of normal and abnormal obstetrics is covered in a brief but lucid manner. The diagrams are adequate and the sparse photographs excellent. The care and treatment of the newborn is a valuable section, particularly to the obstetrician entrusted with neonatal care.

The chapters on family planning, hospital admittance and maternal mortality studies help to make this textbook distinctive. Hormonology is presented in a manner which spares the reader from wading through complicated experiments while seeking the state of present knowledge.

However, the extensive histochemical observations of normal human endometrium seem to deviate from brevity and reflect the special interest of the authors.

Specific methods of treatment given are those in common use throughout the country. The minor differences which are noted do not detract from the book. For example, the intramuscular use of oxytocin for induction of labor is condemned but many obstetricians consider this method to be a satisfactory one. More agreement will be found with their disapproval of sparteine sulfate as an induction agent. Diluted oxytocin by intravenous infusion is the method preferred by the authors.

The aim for a concise book must of necessity result in a brief one. It will be necessary for the individual seeking more than basic knowledge to rely upon other sources, and it is regrettable that the editors have not included a more extensive bibliography.

This book is easy to read and will fill a need for those seeking knowledge at a level between a synopsis and a more comprehensive textbook.

Cecil L. Grumbles, M.D.

OPHTHALMOLOGY — PRINCIPLES AND CONCEPTS: by Frank W. Newell, M.D.; Published by the C.V. Mosby Company, St. Louis, 1965; 491 Pages; Price, $12.25

This new text by an excellent teacher, researcher, and clinician — Frank W. Newell, M.D. — fulfills in large measure the purpose for which it was written, namely " . . . to integrate the basic disciplines both with ocular diseases and abnormalities and with the ocular manifestations of systemic disease."

The text is divided into four parts: Part I — Basic Mechanisms; Part II — History taking and examination of the Eye; Part III — Diseases and Injuries of the Eye; Part IV — Systemic Diseases and the Eye.

Texts of this type, which attempt to cover large areas of Ophthalmology for medical students and graduates, all too often do so at the expense of one section or the other. This work on the other hand emphasizes principles and concepts without bringing the

(Continued on Page 812)



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shock and angioneurotic edema with respira
difficulty, both reversed with appropriate ther
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depression.

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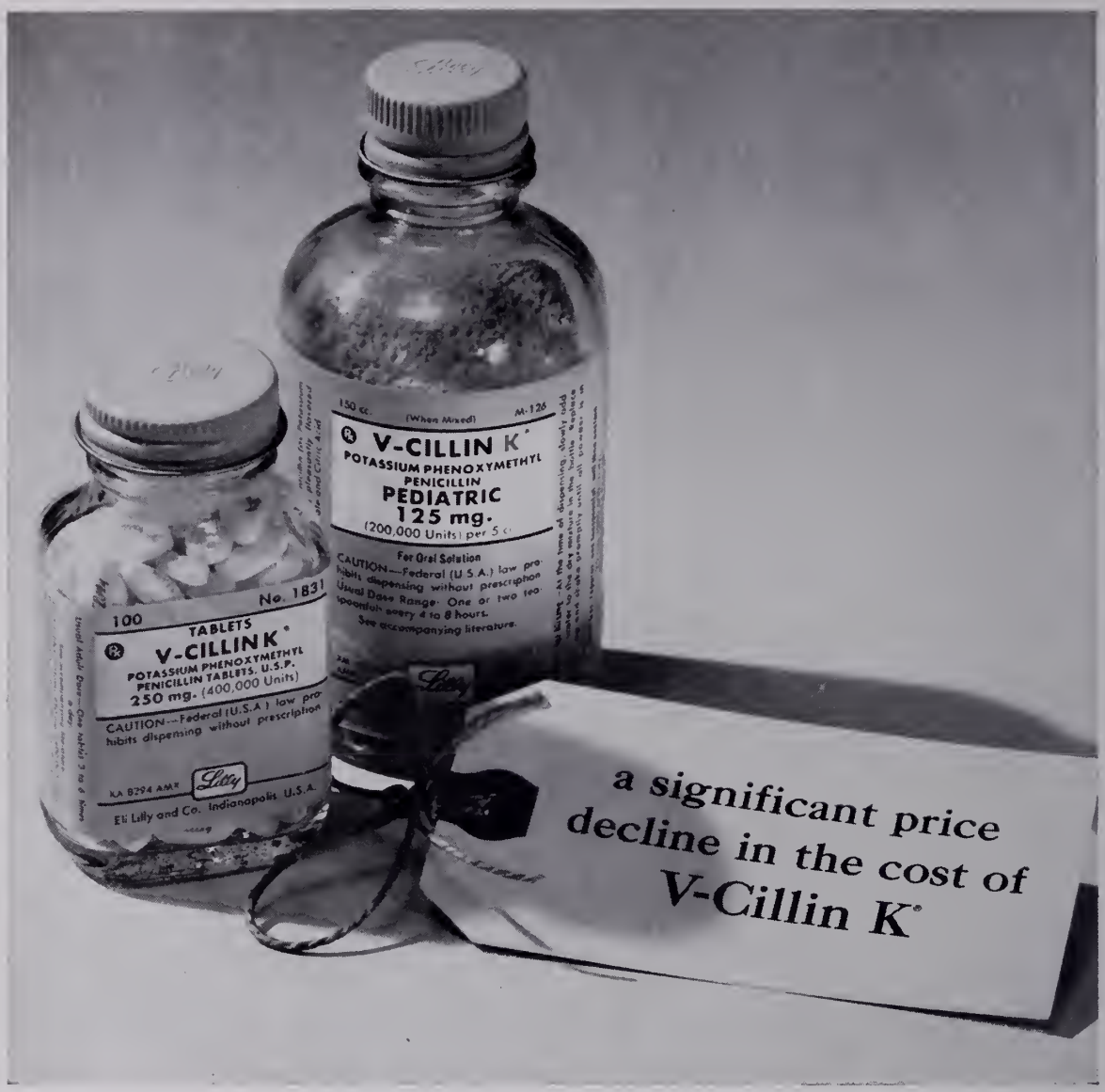
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Fetal and Neonatal Jeopardy†

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Newer methods for monitoring of the fetal heart are far more reliable and provide information of great value in the safe conduct of delivery and certain procedures such as exchange transfusion.

OVER the centuries estimates of the condition of the fetus in utero have been based upon superstition, experience and finally on clinical judgement aided by one or two late signs of acute fetal distress. Researches in the fields of biochemistry and electronic engineering show promise of placing the physician's assessment of intrauterine fetal jeopardy on firmer, more objective grounds.

In dealing with high risk pregnancies there are no substitutes for good prenatal care and engagement of full cooperation of the patient if a realistic period of viability is to be reached successfully. From this point onward, optimal timing of delivery is the critical issue. All conditions in which early delivery serves the best interest of the mother, the baby or both are fraught with the hazard of substituting a neonatal death for a fetal loss in utero. McElin[18] refers to this situation as the Scylla of stillbirth versus the Charybdis of hyaline membrane disease.

Reliable methods for assessing the degree of chronic as well as acute fetal deprivation will certainly be the first step not only in improving fetal salvage but in reducing the appalling number of disabled or handicapped infants born each year. This goal has not been reached but the outlook is hopeful and improvements in perinatal welfare are continuously reported.

Sixty-one years ago vonWinkler in Germany published his classic treatise on fetal distress. Since then auscultation of the fetal heart has been regarded as the best available evidence of impending disaster. It is disheartening, therefore, that the Queen Charlotte Hospital in London found the diagnosis of fetal distress was made in only 29 per cent of anoxic stillbirths although fetal heart tones were counted every 15 minutes. Meconium staining is seen in roughly 10 per cent of deliveries[5]. The incidence rises to approximately 25 per cent in post term pregnancies. Its reliability as a clinical sign is increased if slow fetal heart rates are found concomitantly. These time tested signs will continue to be of paramount importance in the management of acute situations such as accidents to the placenta or cord or reduction of uterine blood flow due to a sudden episode of maternal hypoxia. However, they must be detected early if cerebral damage is to be prevented.

Chronic Distress

Chronic fetal distress is far less evident and more difficult to assess. Retarded fetal growth or malnutrition observed in association with maternal hypertension or renal disease and in certain cases of prolonged pregnancy are

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clearly examples of long term deprivation of the fetus.[10] The diagnosis of retarded fetal growth is often retrospective rather than current. Fortunately the capacity of the fetus for compensation is considerable and hence retarded fetal growth is not always damaging. Other evidences of damage are even more obscure and difficult to assess clinically. Thus evaluation of the risk to the fetus in cases of maternal toxemia, hypertension, diabetes and RH sensitization poses one of the knottiest problems in obstetrics. It is particularly disturbing in connection with pregnant diabetics in whom intrauterine fetal deaths may occur in the earliest stages of the disease long before hyperglycemia, acidosis or cardiovascular renal complications arise. The management of medical, metabolic and obstetric complications now appears to be grappled with more successfully than the timing of delivery in high risk pregnancy. The arbitrary choice of the 36th week for delivery of the pregnant diabetic or deferment of delivery in favor of treating this or other medical complications conservatively should be reviewed in the light of presently available methods for quantitation of hormones of pregnancy. Of the various measurements of chorionic gonadotrophin, metabolites of progesterone and estrogen, reliable information concerning disturbances in placental function and impending fetal death during the second half of pregnancy is found only in serial 24 hour urinary estriol determinations[29, 30]. Although the production of estriol is not peculiar to the placenta the amount contributed by the mother is negligible and does not influence the daily excretion value significantly. The exact source of the estriol has been a matter of controversy. The concept that estriol is produced by the placenta, probably by the syncytial cells, and therefore represents purely placental function, was generally accepted until Scandinavian investigators raised reasonable doubts[4, 6]. Cassmer[4] in carrying out a therapeutic interruption of pregnancy by the vaginal route, dilated the cervix, brought down the umbilical cord which was ligated and sectioned. Fetus and placenta remained in situ for three days. The estriol values dropped 70 per cent below their previous values, progesterone only 20 per cent below previous levels and chorionic gonadotrophin remained unchanged. A living fetus, therefore, appeared essential for maintenance of high estriol excretion although the author was able to maintain moderate estriol values if the placenta in situ were perfused after the fetus was removed from the uterus. The most recent work of Diczfalusy[6] and Haynes[6, 11] in Sweden is more definitive. Their studies of the metabolic pathways of estrogens in the feto-placental unit by use of radio-isotopes demonstrate that the fetus actively conjugates estrogens, largely in the sulfate form. Hydrolysis of estrogen sulfates formed by the fetus appears to be a function of the placenta before transfer to the maternal side, the major portion of the estriol recovered from the placenta being in the unconjugated form. Irrespective of its original source the amount of estriol excreted in maternal urine represents a certain feto-placental work capacity. It seems reasonable to assume that fading ability of the feto-placental unit to perform this function is a reflection of decline in other critical gestational functions. The amount of estriol excreted daily in the third trimester of normal pregnancy is quite sufficient to permit detection of significant quantitative changes. There is still work to be done with respect to various factors that may influence estriol excretion such as renal clearances or the effect of therapeutic measures employed in complicated pregnancy. However, Greene[9] and others in this country, Banerjea[1] and others in Great Britain, Frandsen and Stakemann[7] in Sweden have applied the test for 24 hour urinary estriol levels to the study of a very large number of normal and abnormal pregnancies. Each of these groups has demonstrated that the fetus is in grave danger when estriol excretion is consistently low and on the contrary the fetus is safe when estriol excretion remains high.

Current Studies

Methods of assessing fetal and neonatal welfare are currently being studied at the Woman's Medical College of Pennsylvania. High risk pregnancies are observed at frequent intervals prenatally and studied from both viewpoints. Serial fetal phonocardiographic and electrocardiographic tracings are recorded and studied. Fetal heart rate patterns and electrocardiograms are monitored during labor, delivery and in the neonatal period. On the same patients 24 hour urine samples are obtained at appropriate intervals and estriol excretion determined as a measure of placental

sufficiency. The colorimetric method described by Greene and Touchstone[9] is employed. We have used gas chromatographic methods[28] and although the values obtained for estriol are slightly higher by this method the colorimetric test has proven satisfactory and at present more practical. Our experience with estriol determinations in 112 patients corroborates the work of Greene[9] and his associates, and of Zondek.[29] Actual values obtained in our laboratory are closer to those reported by Greene. Daily variations in estriol excretion values are common but precipitous drops below 50 per cent of previous values are warning signals. Fetal welfare is threatened when values in the range of 4 mg. are found and fetal death is almost inevitable if the daily excretion is below 2 mg. The test has proved useful in the management of complicated pregnancies, particularly those usually associated with placental dysfunction. These include hypertension, preeclamptic toxemia, postmaturity and diabetes. Perhaps its greatest value is in optimal timing of delivery for pregnant diabetics. It has not been useful in detecting fetal jeopardy due to erythroblastosis. The following examples are illustrative of its use in timing delivery.

D.W., an obese 35 year old, para III gravida VII, whose expected date of confinement was July 21, 1964 had diabetes but did not require insulin for control. She had a poor obstetric history. Her last three consecutive babies were stillborn and oversized. Urinary estriol determinations were as follows: 5/5-4.6 mg.; 5/9-9.5 mg.; 6/9-13.7 mg.; 6/18-138 mg.; 6/25-9.3 mg.; 6/29-6.0 mg. This precipitous drop suggested failing placental function, perhaps insufficient to withstand long or difficult labor. On 6/29/64, when the low estriol value was obtained, termination of pregnancy was elected although her clinical condition was unchanged. The membranes were ruptured and Pitocin induction started. Fetal heart patterns were monitored throughout. When induction failed to initiate labor within two and a half hours and early evidence of fetal distress in the heart rate pattern was seen the patient was delivered directly by caesarean section. The baby was a female, 7¼ pounds, whose condition was satisfactory.

It is ironic that in diabetic women the menstrual cycles are so frequently irregular that estimation of the expected date of confinement is often uncertain when accuracy is most essential. Estriol determinations can be as useful in indicating that pregnancy can continue toward a more favorable gestation as they are in the reverse situation. For instance Mrs. L. M., a 21 year old, para I gravida II had an estimated date of confinement of January 25, 1964. The patient was a juvenile type diabetic. Her previous child born by caesarean section at 36 weeks weighed 9 pounds 1½ ounces and survived. With the present pregnancy the patient was admitted on December 12, 1963, with a urinary tract infection. The baby did not seem as large as at the comparable gestation during the previous pregnancy and she did not have hypertension or any other factor which might have accounted for the difference. Estriol excretion at that time was 5.7 mg. but after the urinary tract infection was controlled urinary estriol December 18 was 11.5 mg. and December 23, 11.68 mg. Elective repeat caesarean section was performed on December 25, presumably at 36 weeks gestation. The baby weighed 7 pounds 6 ounces, approximately 2 pounds less than the previous infant and almost certainly was less mature. Respiratory distress developed within the first 24 hour period and the infant died on the second day. Postmortem examination revealed no abnormalities other than hyaline membrane disease. The prenatal estriol values here indicated that the baby was in good condition.

In contrast G.R., a 28 year old, para O gravida I was a diabetic although not insulin dependent. Her expected date of confinement was doubtful but was estimated to be January 30, 1964. Estriol excretion values were as follows: 12/3-7.8 mg.; 12/18-7.2 mg.; 12/26-9.4 mg.; 1/7-9.32 mg.; 1/13-10.4 mg.; 1/19-8.5 mg.; 1/27-10.6 mg.; 2/2-12.0 mg.; Despite the fact that the pregnancy had gone beyond the presumed due date obstetric interference was avoided. Vaginal delivery on 2/10/64 resulted in a normal female infant weighing 8 pounds 9 ounces whose condition was good.

It appears quite certain that low urinary estriol values reflect chronic fetal distress or deprivation. Depending upon its degree the fetus may be incapable of withstanding the stress of labor. The most discriminate and immediate information needed in dealing with subacute and acute fetal distress is still,

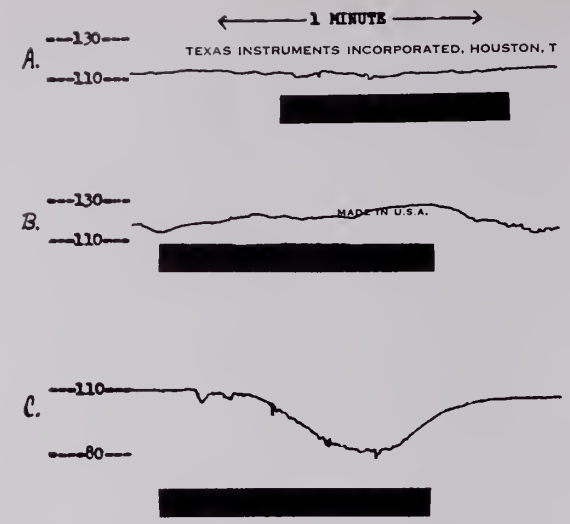


FIGURE 1. Instantaneous Fetal Heart Rate Patterns in Normal Labor. The time between successive heart beats is measured and the reciprocal of this measurement (i.e.: the instantaneous pulse rate, which is the pulse rate per minute which would exist if all beats in that minute were separated by the time period measured) recorded automatically. The instrument is calibrated linearly with respect to pulse rate; the paper moves 1 millimeter per second. Uterine contractions are indicated by the solid bar. (A). The fetal head is not engaged. Uterine contraction produces no significant change in the pulse rate. The minimal irregularity of the rate line (phasic variation) is a normal phenomenon. (B). The fetal head is high and barely engaged. Uterine contraction produces a pulse rate rise. (C). The fetal head is deep in the pelvis. Uterine contraction produces a significant bradycardia. Note the smoothness and the gentle shoulders of the curve.

after more than half a century of searching, found in some form of monitoring of fetal cardiac activity. Hopefully, modern methods will improve end-results.

Continuous Recording

Continuous counting and recording of the fetal heart rate by electronic means has proven a far more reliable indicator of fetal well-being than intermittant auscultation with a fetoscope. Dangerous abnormalities of fetal heart rate often last for only 20 to 60 seconds and occur primarily during uterine contraction when fetal heart tones are particularly difficult to hear. Auscultation for a full minute every 15 minutes provides less than one chance in 16 that such an abnormality in fetal heart rate will be present during examination. Furthermore, clinical auscultation permits the assessment of the pulse rate in average terms only, whereas electronic methods trace the pattern of pulse rate change from moment to moment. These patterns, primarily a function of the fetal cerebral medulla, contain diagnostic information not found in the average pulse count.

The methods for making instantaneous fetal heart rate recordings have become well established[3, 13, 14, 21, 25]. All require that an electrode be brought into direct contact with the fetus in utero. No serious complication has attended this procedure. The time between successive fetal electrocardiographic QRS complexes obtained by means of the fetal electrode is measured. Its reciprocal, i.e., the fetal pulse rate, is calculated electronically for each beat pair and a signal proportional to this figure is recorded. The succession of these signals inscribed on a strip chart is the "instantaneous fetal pulse rate pattern".

Before labor begins, the fetal pulse rate varies irregularly by ±5 beats per minute with a peak to peak recurrence every 5 to 20 seconds (Figure 1A). The pulse rate most frequently encountered during this period is between 110 and 140 beats per minute. As labor progresses and the head descends the irregularity of the heart rate line increases during uterine contraction with a peak to nadir spread from 10 to 40 beats per minute. Initially the rate line swings enlarge by an increase in the peak value; then the duration of the elevated peaks increases with uterine contraction (Figure 1B). As the head descends deeper into the pelvis the rate rise is often terminated by a steep rate fall. This fall becomes longer, replacing more and more of the rate rise during uterine contraction until just before delivery when a pure rate fall with no initial rise is the rule (Figure 1C). Falls accompanying uterine contraction become deeper as labor progresses beginning with falls to 90 or 100 beats per minute and often ending with nadir rates of 60 to 80 beats per minute.

Intrauterine pressure monitored simultaneously with fetal heart activity demonstrates that the fetal heart rate changes occur at various times during the pressure rise of uterine contraction, at times beginning before the pressure rise, at other times beginning thereafter. Just before delivery the rate fall with uterine contraction often persists into uterine relaxation and, upon crowning, continues until delivery. Between rate changes during uterine relaxation, the pulse rate normally returns to its original level.

Instantaneous heart rate patterns accompanying abnormal presentations are distinctly

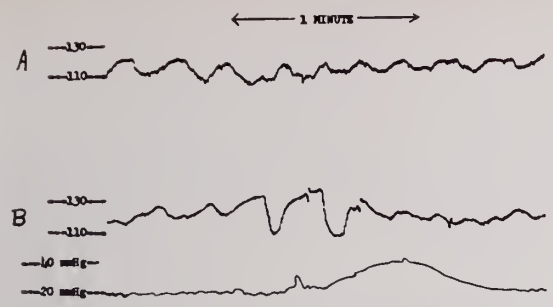


FIGURE 2. Instantaneous Fetal Heart Rate Patterns in the Occiput Posterior Position. The recordings were made as in Figure 1. The lower curve in b) represents the amniotic fluid pressure measured by a pressure transducer inserted through the uterine cavity. Isee text) IA). In uterine relaxation: Note the marked irregularity of the curve, and the steepness of ascents and descents. IB). With uterine contraction: Note the increase in heart rate irregularity preceding and accompanying the amniotic fluid pressure rise. The change in fetal pulse rate preceding amniotic fluid pressure rise suggests that the uterus may contract and displace the fetus before amniotic fluid pressure begins to rise (isobaric uterine contraction).

different from those associated with normal presentations. In occiput posterior positions marked irregularity of the rate line is seen frequently during as well as between uterine contractions[19] (Figure 2). This marked variation is replaced by the normal pattern when rotation of the fetal head occurs.

In breech presentations there is little or no heart rate variation until the second stage of labor unless the umbilical cord is occluded. This finding has aided in determining those patients in whom decomposition and extraction should be carried out promptly and those in whom conservative management is safe. The fetal pulse rate drops seen in late labor in normal vertex deliveries can be reproduced by fundal pressure in breech positions but they do not usually appear spontaneously.

Fetal heart rate patterns typical of cord occlusion, first described by Hon[12], include long (40 to 80 seconds), U-shaped rate line falls occurring with uterine contraction and sharp, steep falls often occurring within two or three beats, lasting 8 to 15 seconds and independent of uterine contraction (Figure 3).

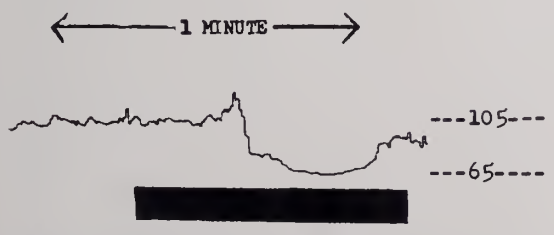


FIGURE 3. Instantaneous Fetal Heart Rate Pattern in Cord Occlusion. Uterine contraction is indicated by the solid bar. Note the steep rate of fall and tub shaped bradycardia with uterine contraction. The bradycardia of cord occlusion may be noted long before the head is engaged, and is not necessarily associated with uterine contraction.

Abnormally short cords are also accompanied by U-shaped rate falls but the dips occur later in relation to the uterine contraction. Presumably the cord is overstretched as the uterus re-expands and blood flow through the cord is slowed. In any case, this type of rate change has been seen in each of the three short cord cases monitored.

Fetal tachycardia is usually considered less significant than bradycardia. Persistent rates over 160 beats per minute have proved to be significant. At the time of delivery 80 per cent of infants showing high cardiac rates during labor had varying degrees of difficulty.

Complicated Labor

Monitoring probably renders most assistance in management of cases in which some degree of fetal compromise may be anticipated. We have monitored most labor complicated by diabetes, preeclampsia, hypertension, postmaturity, Rh sensitization and partial placental separation. The incidence of caesarean section has not been increased by its use. On the contrary, the security of observing fetal heart rate patterns within the limits of safety has frequently prevented unnecessary interference. It has added considerably to the confidence with which Pitocin inductions or assists are conducted in complicated pregnancies.

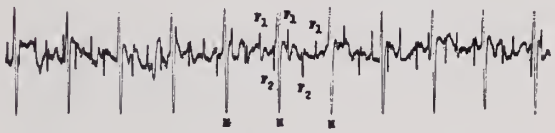


FIGURE 4. Transabdominal Electrocardiogram of a Twin Pregnancy. Note that three distinct electrocardiographic QRS complex configurations are present: the largest one is produced by the mother's heart, a small predominantly positive one is produced by one twin (F^1), and a small predominantly negative one is produced by the other twin (F_2). The divergent direction of the two fetal signals is due to the twins' positions: one in breech, the other in vertex presentation.

Analysis of the configuration of the fetal electrocardiogram obtained either through the maternal abdominal wall or from the fetal scalp electrode renders information concerning the fetal heart rather than the cardiovascular control center in the brain. Recent engineering advances have greatly improved the recorded fetal EKG. This type of recording aids in the diagnosis of fetal life in doubtful cases and permits the diagnosis of twins without x-ray exposure (Figure 4). The relationship of fetal positions can be determined by polarity of

the EKG. The polarity is in the opposite direction if one twin is in vertex position (Figure 4) and the other breech and conversely, polarity is in the same direction if positions are the same. In view of the improvement in prevention of premature delivery and in fetal salvage reported by Barter when the diagnosis of twins is made before the 28th week of pregnancy and bed rest instituted, we are monitoring all patients in the prenatal clinic when the diagnosis is suspected. This is repeated on several occasions before ruling out the presence of twins in early pregnancies. The EKG can be obtained by the 16th week and is generally obtainable when the pregnancy is of 24 or more weeks. When clinical findings suggest fetal death, the loss of fetal heart recordings together with extremely low urinary estriol values in the second half of pregnancy makes possible earlier intervention. Labor and delivery can be accomplished by the intra-amniotic administration of hypertonic saline solution without the long period of waiting for spontaneous onset of labor and the associated hazard of coagulation defect.

Abnormalities of the fetal EKG in fetal distress associated with congenital heart disease have been described by Larks[17] and Kendall[16]. These consist primarily of notching and widening of the QRS complexes. If this type of evidence of fetal distress is seen during labor it is not related to the labor and therefore hasty delivery by Caesarean section will probably not result in improvement.

Whenever possible, amniotic fluid pressures are recorded and relationship to the instantaneous fetal heart rate patterns observed. A 7F cardiac catheter tipped with a semiconductor strain gauge bridge is introduced into the uterus through the cervix just before the fetal scalp electrode is applied. The tip is positioned to lie above the fetal head. Minimum pressure in most patients is 20 mm. Hg. Maximum pressure exerted by the normal uterus in the absence of skeletal muscle contraction or external assistance is approximately 130 mm. Hg. Occasionally a steep or rapid rise is seen followed by a slow fall. Such patterns are often followed by a long pause comparable to cardiac "extra-systole". (Figure 5). In some patients pressure peaks diminish as labor progresses. These findings are usually associated with excessive sedation or dystocia. Administration of Pitocin immediately increases the strength of contraction. The recording permits accurate quantitative assessment of uterine activity.

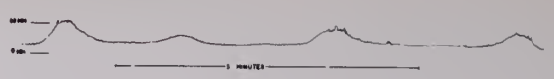


FIGURE 5. Amniotic Fluid Pressure in Labor. Pressure is measured by means of a catheter tip transducer positioned in the amniotic fluid far above the presenting part. The undulations of the line during uterine relaxation are due to maternal respiration. The irregularities at the peaks are due to abdominal muscle contraction and motion. Note that contraction #2 occurs prematurely and has a diminished height.

Monitoring Newborns

Automatic recording is continued into the newborn period in problem cases and compared with the findings in normal newborns. Electrodes are glued into the newborn child's axillae immediately after delivery. The single lead electrocardiogram obtained by the electrodes is transmitted by FM radio[16] to a receiver-recorder and a rate meter, which measures the time between successive electrocardiographic QRS complexes, calculates the reciprocal of this time i.e., the instantaneous heart rate, and records a signal linearly proportional to this value along with each electrocardiographic wave. The inscription of the succession of signals on a strip chart forms the "newborn instantaneous heart rate pattern".

The characteristic normal and abnormal curves have been described in detail elsewhere[24]. Normal newborn children demonstrate an irregular sinus node rhythm with a peak to nadir spread of from 3 to 30 beats per minute (Figure 6). The peaks of the irregularity may be 6 to 30 seconds apart. The pattern may be rather straight immediately after birth but in normal infants it becomes angular within 3 to 13 hours after delivery. It is interrupted by a smooth parabolic rate rise when the child cries, and deep, V shaped falls with hiccoughing. The pulse rate variation due to breathing, which is always present in adults and older children, is not present in newborns unless the airway is impaired. The degree of respiratory pulse rate variation may be slight (1 to 2 beats per minute peak to nadir), or marked (15 to 30 beats per minute peak to nadir), being roughly correlated to the severity of airway obstruction. A perfectly flat, unvarying rate line is seen only in children who are ill, or have been exposed to noxious maternal influences (preeclampsia, diabetes, etc.). A 60 per cent mortality rate is associated

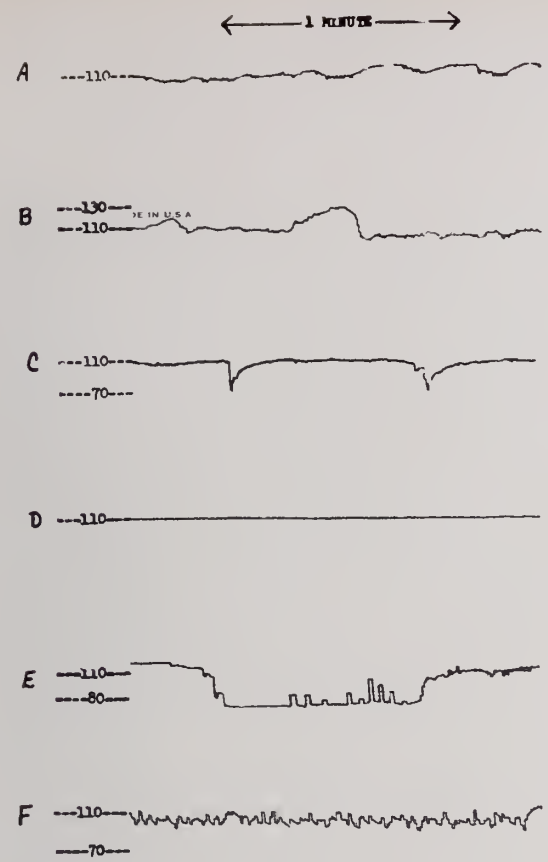


FIGURE 6. Instantaneous Newborn Heart Rate Patterns. The curves were recorded and calibrated like the fetal heart rate patterns in Figure 1. (A). "Phasic variation": Note the moderate irregularity which is not associated with respiration. (B). "Cry pattern": Crying and other Valsalva maneuvers produce a smooth parabolic rate rise which interrupts the phasic variation of the resting child. (C.) "V shapes": Hiccoughing and other Mueller maneuvers produce sharp steep negative deflections. These are infrequently seen after the third hour and rarely after the 12th hour of life. (D). "Flat line": Note the absence of irregularity. This pattern is distinctly abnormal, and is associated with a high mortality rate. (E.) "Bradycardia": Pulse rate falls persisting for 30 seconds or longer are probably due to short periods of asphyxia and are also associated with a high mortality rate. (F). Marked respiratory pulse rate variation: Inspiration is accompanied by a rise, expiration by a fall in pulse rate. Such patterns are usually associated with airway obstruction.

with this pattern. It is frequently observed hours or days before other clinical signs of illness appear. Paroxysmal bradycardia during which the pulse rate may fall from 30 to 60 beats per minute for 30 to 80 seconds is also associated with a very poor prognosis. Sixty per cent of children demonstrating this abnormality in our series died, and the rest were ill but recovered. This pattern is also observed hours or days before other evidence of abnormality has appeared. Newborn monitoring has alerted the pediatrician to problems, not all of which are correctable but has been of great value in the safe conduct of certain procedures such as exchange transfusion.

SUMMARY

In certain complications of pregnancy (diabetes, cardiovascular renal disease, preeclampsia, postmaturity) the fetus appears to suffer gradual or consistent deprivation. Chronic fetal distress can best be assessed by use of serial urinary estriol determinations.

It is likely that both fetal and placental metabolic activities contribute to the estriol pool.

Subacute and acute fetal distress is most accurately assessed by monitoring the fetal heart.

These diagnostic aids used advisedly in the management of high risk pregnancies can serve as useful a purpose in preventing untimely or unnecessary interference in some of the problem cases as they unquestionably do in pinpointing the need for early delivery in others.

Monitoring of the newborn infant provides an objective means of evaluating certain clinical conditions and can be of value in safe conduct through procedures such as exchange transfusion.

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(Continued on Page 808)

Psychiatry's Double-Binds†

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Can conflicting demands of our culture serve as schizoprenogenic "double-binds" for a growing profession? Professions, like individuals, can grow through a stage of self assertion to a mature level of creative mutuality.

HUMAN groups, like individuals, seem to follow patterns of growth. Organizations and professions are subject to forces which influence the direction and nature of growth. I propose that we consider the growth of modern psychiatry as it is being influenced by a number of conflicting social demands and conflicting cultural values. We raise this question: Do the contradictory expectations and demands of the society and culture which gave birth to modern psychiatry, constitute the kind of double-binds which are potentially schizophrenogenic[1] in their effect on this growing human group?

It has made sense to me to think of the direction of growth, in both individuals and groups, to be from 1) dependence, through a stage of 2) independence, to the level of 3) inter-dependence. John Whitehorn[2] suggests four stages of growth: 1) Infancy, 2) Childhood, 3) Early adolescence and 4) Late adolescence, with implied emphasis on the continuing immaturity of most humans. It was in a series of encounters with Rodolph Turcotte that I came to think of growth stages in these terms: 1) Helpless parasitism, 2) Controlled conformity, 3) Reckless self-assertion, and 4) Creative mutuality.[3, 4] These stages of growth are roughly comparable to levels of personality integration expressed in psychoanalytic terms as: 1) oral, 2) anal, 3) phallic, 4) genital.

Why drag this business of levels of growth into the discussion of double-binds? If it is true that conflicting cultural expectations for psychiatry can be compared (even with admittedly strained analogy) with the noxious double-binds that threaten the future well-being of a growing individual, then we should concern ourselves with ways of assuring healthy and healthful growth for psychiatry as it continues to mature. A simplified scheme of stages of growth may provide a useful frame of reference for assuring more successful continuing growth toward maturity for a profession just as it does for an individual.

While our focus is on the profession as a whole, we are well aware of the pressures on the individual psychiatrist. There is a gap between what is expected from psychiatry as a profession and what can be delivered by the combined efforts of individual psychiatrists. Each of you can make your own estimate of the size of this gap and draw your own conclusions about its significance. This gap between what is expected and what can be delivered can be seen as an overall double-bind.

One difficulty of bringing into clear focus the comparison of the parent-child relationship to the cultural demands on psychiatry, is that we are involved in multiple cultures. We can, however, look broadly at the expectations of 1) our total society. We could concentrate on 2) the medical community of which psychiatry is a part, or we could focus on the forces active within 3) the family of psychiatry itself. In fact, the very task of viewing clearly the nature of the influences at these three levels presents many alternatives. Which ambivalent or ambiguous elements in the situation can legitimately be viewed as "double-binds"? Which should be viewed as wholesome growth promoting differences? Which represent multiple opportunities to be developed concurrently? In the following examples I would raise questions for your consideration. I do not presume to know the answers. The important use of this hour is the exercise and enjoyment of your own creative thinking as stimulated (hopefully), by this presentation, and even more by

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the discussions of the panel members. We will group these few examples under the general headings 1) Our National Culture, 2) American Medicine, 3) Psychiatry Itself.

Our National Culture

Concepts of "mental illness" and "mental health" are fuzzy rather than clear cut. Classifying unsatisfactory human situations as problems of health, problems of learning, problems of social organization and control, problems of individual or group morals or some other type problems is becoming increasingly difficult. I believe it will get worse before it gets better. It appears that one of our major problems is the cultural norm of seeing life in terms of problems to be solved—the problem of "problem-oriented thinking". It is easy to slip into the habit of thinking of persons primarily as problems. This may be one corallary of too-intensive attention to pathology as compared with growth.

The massive national effort, as reflected in the work of the Joint Commission on Mental Illness and Health, and in the present nationwide planning effort, raises more questions than it answers[5]. This is good; but one of our cultural stereotypes is to demand answers to questions. If there is a question, there should be an answer. If there is not, (it's assumed that) there must be a culpable villain. Our modern culture seems to have a low tolerance for ambiguity. Psychiatry is perceived by some as the villain that fails to meet the magical expectations of the millions who demand quick, easy, pat answers. But here's the bind: the culture says to psychiatry, "Give us the answer," but at the same time it is saying, "We don't really believe you can".

A challenging idea was reflected in a luncheon conversation including several ministers and psychiatrists. This question was raised. If the psychiatrist provides a relationship which is based on love, isn't this a selling of love similar to commercialized traffic in love in other forms, such as prostitution? Should people pay professionals for experience in a relationship which should be a part of ordinary life experience? Another question was also raised about the implications of the so-called pastoral function of the minister. Does this imply that people are a bunch of sheep? Let me comment on questions like this in a round-about way. Look with me at the sources of human knowledge about human feelings and human behavior. Compare the opportunities for fundamental observations in this field of human behavior with, for example, bacteriology and nuclear physics. Special laboratory conditions and equipment required for these specialities, necessarily limit the number of persons who have opportunity for first-hand observation of the basic raw idea. In contrast, every person has lived all his life in a laboratory of human behaviour, human emotions, and human relationships. Specialized human efforts might be ranked in terms of accessibility to the basic observations leading to knowledge on which the specialized skill is based. Specialties based on data most accessible to the ordinary person are apt to be the specialties that are considered most readily expendable. I believe that consciously or unconsciously this consideration influences the public attitude toward psychiatry. Does this contribute to a double-bind relationship between our culture and psychiatry?

There is a common, perhaps universal, tendency to protect against the downgrading or the elimination of a specialized human function by any group of persons who practice the specialized function. Numerous methods are developed for reinforcing the protective devices which assure survival and effectiveness by a group, just as surely as by an individual. One such group reinforcement is the development of an aura of mysticism or magic (which meets needs both for the smaller special function group, and the larger group which it serves). Another and a more constructive method of reinforcement of course, is the development of excellence in the practice of special skills. Both methods can be observed in most specialized practices, including psychiatry. But the "do-it-yourself" drive in our culture is a force existing side by side with the insistent demand for the expert. Does the dynamic equilibrium of these two forces get out of balance and become another double-bind which confronts modern psychiatry?

American Medicine

The current emphasis on strengthening the common bonds of psychiatry with all of medicine is an important effort based on multiple values. These efforts, spearheaded by the Council on Mental Health of the American Medical Association, are complex and present

several ambivalent trends. This was well illustrated by an incident at the opening of the Annual Meeting of the Council in Chicago several years ago. In calling the conference to order, the chairman commented with enthusiasm on the size and significance of the meeting and then made a fascinating slip. He said the opposite of what he meant. It came out, "and this meeting will really mark the separation of Psychiatry and Medicine". Far be it from me to interpret the meaning of his omission of the important words "the end of" before "the separation of Psychiatry and Medicine".

This whole question of the relationship of all of medicine to psychiatry is replete with numerous double-bind type ambiguities. There is a vitally important need to safeguard the quality of specialized medical services. This requires an almost closed system of carefully selected, well-trained persons. Behavior of individual professionals and of professional groups which attempt to insure appropriate safeguards for quality of service, may be perceived as something different by hostile critics; it may be seen as professional ethnocentric behavior or self-centered development of power and monopoly. Usually such varying perceptions can best be reconciled by looking for the partial truth, however large or small, in any honest opinion. But the basic issue related to the bond between psychiatry and the rest of medicine involves varying concepts of the balance placed by the "real physicians" on the body as compared with the person, and on the ways in which this balance helps define the appropriate area of medical practice.

The present state of specilization confronts us with a major question; when does specialized function reach a point of diminishing return? I am not at all sure that conscious analysis and planning will successfully deal with questions like these. There is a "wisdom of the social system" comparable to Cannon's "wisdom of the body" which we quite appropriately depend on for the best combination of many complex forces. One thing is clear. What the specialist does this year is often the responsibility of the generalist or of the individual himself next year (or at some future time). Thus the specialist must "kick off at the heel as fast as he takes on at the head". Psychiatry finds itself increasingly involved in working with people who in turn work with troubled or troublesome people, rather than working directly with the person in need. Beyond this there is an increasing involvement with growth in contrast to pathology. Adequate attention to growth and the nourishment of growth appears often to by-pass or obliterate the troublesome pathology. The increasing emphasis on the person in addition to the human body or organism calls for psychiatrists to strengthen their understandings of social sciences. This is true because the person is more than a body; a person can exist only when there is an existance of the individual as a unit in multiple social system.

Social psychiatry, community psychiatry, and the general broadening of interest in social systems, as well as in individuals, bring psychiatry and public health closer together. Both specialties feel the need to continue to prove they are "real doctors". Both are aware that treatment of sick individuals is only part of the task of assuring a high level of health for total populations. And it is obvious that demands will continue to exceed resources.

Any one of these brief statements could be elaborated into a description of double-binds confronting psychiatry in relation to its position in American medicine.

Psychiatry Itself

The realm of psychiatry has expanded at a rate and in some directions that have led to words of caution from its own membership. It was interesting to hear rumblings from some who perceived some of these warnings as an attack on psychiatry. For example, I know some psychiatrists who questioned whether someone could really be a loyal psychiatrist and write about "The Myth of Mental Illness"[6]. In Georgia, it has been interesting to receive criticism from two directions at once. One accusation was that our program encouraged too much shock therapy; at the same time others accused me of being unduly influenced by "non-medical" psychiatrists who used no shock therapy and little drug therapy, and therefore weren't "real doctors". Some psychiatrists feel keenly that mental health programs should include mental retardation and alcoholism and juvenile delinquency—others feel this is going too far

afield. Some of our Georgia psychiatrists feel that no clinical training should be wasted by doing anything but treat sick people; others are convinced the real future role of the psychiatrist is mainly in the area of consultation. The continuing search for more explicit role identity and appropriate balance of function is characteristic of a living, growing profession. Continuing and rigorous self-examination is as helpful to a profession as it is to an individual.

In Georgia's Community Hospital Psychiatric Program[7] we see a range of possible relationships between hospital psychiatric services and other general hospital departments. In the business end of private psychiatric practice we see varying attitudes. For example, while we have a pay schedule for psychiatrists, two of them in one hospital decided to provide free limited service to indigent patients in the same way other physicians on the hospital staff do.

Are these differences within psychiatry a wholesome range of diverse methods which are appropriate and growth-promoting? Or is the profession burdened with some schizoid tendencies which might be traced in part to the pressure of cultural double-binds? I would hazard the suggestion that one characteristic of maturity is the capacity to utilize ambiguity in a constructive way which increases creative productivity.

Apparently, there are at least two distinct psychiatrys, and possibly many more. Psychiatry-1 is a clinical medical specialty. It is appropriate that the clinical medical specialty of this psychiatry be safeguarded by carefully protecting society against practice by unqualified persons. On the other hand, there is Psychiatry-2 which is one of the basic behavioral sciences. The application of knowledge and understandings from the basic science of psychiatry has become not only the right but the responsibility of every person dealing with other human beings. The psychiatrist seeking the appropriate balance of role function finds that he is not only a "diagnoser and treater", but a "growth helper", and many other things.

These diverse concepts within the profession as to what psychiatry really is may frequently present conflicting demands. Whether these conflicting forces are helpful or detrimental to a growing profession depends to a large extent on how they are perceived and how they are handled.

Summary

This brief discussion has pointed to a few of the many forces influencing the growth of psychiatry, from the general culture, from general medicine, and from psychiatry itself. Many important ones have not even been mentioned, such as balances of public and private services and interdisciplinary team functions and the division of or overlapping of functions.

The question is raised, whether some of these forces conflict in such a way as to constitute double-bind situations which may threaten the future health of a growing profession in a manner roughly similar to the suggested schizophrenogenic influence of double-bind situations in the growth of children.

It is suggested that questions of this type be explored against the background of some simplified outline of stages of growth which may apply to groups as well as to individuals.

My personal conviction is that the self-assertion of the profession is a sign of health which will minimize the danger of ill effects from conflicting cultural forces. It appears that individuals cannot grow from a level of controlled conformity to a level of creative mutuality without experience in self-assertion. So it is with groups and professions. The strength required to stand together in a mutual relationship requires first the strength to stand alone. However, the same caution in regard to continuing growth applies to professions as to individuals. We must avoid fixation at a lower stage of growth. The self-assertion must be used as a stepping stone to the more mature level of creative mutuality.

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SEARLE *Research in the Service of Medicine*

Allergy in Chest Disease†

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In the differential diagnoses of diseases of the chest the inclusion of an allergic evaluation, including simple screening skin tests is necessary for an adequate assay.

ALLERGY plays a minor roll in the total consideration of chest disease. Hinshaw and Garland[1] in the 1963 edition of *"Diseases Of The Chest"* devoted but 20 pages to their chapter on bronchial asthma and related conditions.

Chest physicians have been so occupied with infectious respiratory diseases that only recently have they been able to disengage partially from that battle and consider other pulmonary disorders including allergy of the respiratory tract. Some states (unfortunately not including Kentucky) have experienced sufficient decline in the number of cases of pulmonary tuberculosis that beds and personnel no longer required have been made available for the treatment of patients with asthma. Improved treatment is provided not only in tuberculosis but also in bacterial, fungal, viral and rickettseal pneumonias, in atelectasis, bronchiectasis, cardiac arrythmias and arrest, as well as in many surgical diseases of the heart and lungs. It would seem that chest physicians through their increasing competence literally might work themselves out of jobs. In this remote possibility allergy might be considered as an interesting and uncrowded specialty to which they could adapt readily. A greater motivation should be desire for knowledge of allergy since few residencies provide training in this field. Physicians interested in chest disease should acquire understanding of hypersensitivity in the cardiopulmonary system sufficient to apply these principles to the differential diagnoses and if desired, the treatment of allergic disease.

Allergy of course is concerned not only with manifestations in respiratory disease but with antigen-antibody reactions in all the body tissues, including skin, mucosa, muscle, connective tissue, blood vessels and in fact all cellular structures which can act as shock organs.

History of Allergy

Allergy is a relatively young specialty. Before discussing its specific relation to chest disease certain of its tenets should be explained and some of its history and heroes be introduced.

In little more than half a century allergy has become a respected specialty. It has weathered a storm of incredulity and has seen its principles accepted into the therapeutic armamentarium of many groups, some of whom were the most incredulous.

Isolated cases of hypersensitiveness have been mentioned since the days of Hippocrates. Physicians in the middle ages were aware that exposure to certain flowers, foods and animals caused episodes of asthma in some people.

In 1819 John Bostock, a physician in London, described hayfever as a new disease and after nine years search was able to find convincing evidence of but 28 cases in all of Europe.

Robert Koch, in 1891, developed the subject of bacterial allergy by his report that tuberculous animals became sensitive to ordinarily non-toxic injections of tuberculin.

Charles Richet, in 1902, described the phenomenon which he called "Anaphylaxis".

In 1906 Schick and von Pirquet promulgated the principles which became the basis of modern allergy and they coined the term "Allergy". They introduced a cutaneous tuberculin test by scarification which led to the present-day skin testing. Blackley, in 1873, previously had demonstrated pollen sensitivity on himself by ophthalmic, nasal and scratch tests but this work unfortunately had fallen

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into oblivion. Even before this, in 1860, Hyde Salter, who was sensitive to cat hair, described tests on himself. After handling a cat then touching his eye he developed an ophthalmic reaction, and allowing the cat to scratch him produced a local wheal and urticaria.

In recent years clinical immunology and allergy has made tremendous strides. Among the outstanding contributors, to name a few, have been A. F. Coca, Mathew Walzer, Robert Cooke, Frances Rackemann, Aaron Brown, W. B. Sherman, Erich Urbach, Louis Tuft, J. Harvey Black, Warren Vaughan, Samuel Feinberg, Leo Criep, Leon Unger, John Sheldon and, of local as well as national importance, Milton B. Cole and Henry Beckman.

Prior to 1944 there were two national allergy societies, an Eastern group, The American Association for the Study of Allergy, and a Mid-western, The Association for the Study of Asthma and Allied Conditions. These amalgamated to form the present American Academy of Allergy, which has a membership of 1,465 physicians from the United States, Canada and thirty other countries. Together with another large national allergy society, The American College of Allergy, (647 members), support is given to the Foundation of Allergy and to the International Association of Allergology. There are also a number of state and regional allergy societies.

The Journal of Allergy and The Annals of Allergy are among a number of well recognized medical magazines devoted to the specialty.

The A.M.A. at its convention in June, 1964, approved the establishment of a section on allergy. For some years the Southern Medical Association, The American College of Chest Physicians and a number of state-medical societies have had such sections.

The Federal government supports the National Institute of Allergy and Infectious Diseases which supervises its grants to more than 2,000 research projects in laboratories, hospitals, universities and medical centers within the United States and in some foreign countries.

Allergy Incorporated Into Other Specialties

In the formative years of allergy, those primarily interested were internists, immunologists, pediatricians, and as I recall, one dermatologist, Marion Sulzberger. In those pre-antibiotic days Otolaryngology was chiefly a surgical specialty and hayfever was sometimes treated by cauterization of the nasal mucosa with electrophoresis, chemicals and actual cautery. The adoption of allergy by otolaryngology was well illustrated by the address of Jack Anderson, M.D.,[2] the guest speaker at the 1963 meeting of the Kentucky Eye, Ear, Nose and Throat Society. He began his presentation with the statement, "Most otolaryngologists will agree that allergy is the leading cause of chronic nasal disorders". He advised the members to acquire training in allergy which 'Would provide scientifically fascinating and emotionally rewarding facets to that specialty'. The further motivation which he suggested, perhaps facetiously, might not so readily be agreed upon. He stated, "Besides, as we always point out when teaching our residents. their ability to treat allergic patients can be as valuable as an annuity, for they can continue this type of practice when they can no longer operate, after they have had their coronaries (God Forbid!) or when they decide to go into partial retirement".

It should not be difficult for the chest physician readily to acquire the techniques for the diagnosis and treatment of allergic disease of the lungs. He has the desirable basic training in immunology, is familiar with scratch, intracutaneous and ophthalmic allergy testing, and most importantly possesses the patience and philosophy required to deal with individuals suffering from chronic or intractable maladies. The chest physician has acquired his competence through laborious study and apprenticeship and is not apt to accept other than adequate training in allergy as the qualification necessary to its therapeutic application.

Post-Graduate Training in Allergy

The physician interested in allergy either as a specialty or as a sub-specialty should, if practicable, avail himself of the excellent one to three year residencies or fellowships offered by a number of medical schools. When this is not feasible, he should attend continuing education courses such as listed in the Aug. 10th, 1964 J.A.M.A., and recognized post-graduate courses such as those given by the American College of Chest Physicians or by the national allergy societies. I would recommend supplementary reading including

Clinical Immunology and Allergy,[3] a recent and most comprehensive textbook by Leo H. Criep, M.D., also a programmed course for physician self-study entitled Allergy and Hypersensitivity, developed by Basic Systems, Inc., for Chas. Pfizer & Co., Inc. This may be obtained free from that company.

No amount of reading or lectures, however, can take the place of actual experience with patients and of working under supervision in the allergy laboratory. There is no short cut to proper training in allergy any more than there is to any other medical training program. The doctor who is responsible for administration of allergic treatment deals with a modality which in inept or inexperienced hands could be as lethal as a knife in the hands of an incompetent surgeon.

Extrinsic Asthma

The National Tuberculous Association in 1960 estimated that more than three million people in the United States suffered from asthma.

The classification of asthma proposed by Milton Cole[4] in 1944 remains most useful. He suggested the terms extrinsic, for allergic asthma; intrinsic, for asthma due to infection or other bronchial obstruction of non-antigenic origin and combined, as the name implies when both conditions exist simultaneously. Extrinsic (allergic) asthma is characterized usually by onset early in life, a personal or family history of allergy, the presence of specific antibodies, mucoid bronchial secretions containing eosinophils and episodes of recurrent dyspnea, orthopnea, wheezing and cough which at first is reversible, but later may become chronic, intractible or complicated with emphysema. Skin tests to specific antigens are usually positive. The response to allergic treatment is satisfactory.

If neither history nor skin tests aid in the diagnosis, environmental testing may aid in evaluating the etiologic factors. Placing the patient in a special allergy-free room in a hospital or having him visit an area of the country free of the suspected allergen should cause prompt amelioration of his symptoms.

Specific Treatment

In the treatment of extrinsic asthma the ideal of course is to eliminate specific offending agents. This is readily done if the allergen is evident such as the family cat, the wife's perfume or the fish on Friday. If it is a psycho-somatic problem or if the allergen is not evident the problem may be difficult.

Ragweed pollen which may cause asthma in the late Summer and Autumn constitutes about 90 per cent of the pollen "fallout" in Kentucky. It is absent or present in clinically unimportant amounts in the far West and in the Miami area of Florida. Sufferers from ragweed often can conveniently take their vacations in ragweed free areas. A list of the areas in America showing their ragweed pollen counts can be obtained from Abbott Laboratories or The Allergy Foundation of America. Unfortunately grass pollens and fungi are universal although less abundant in some areas. The use of air coolers plus keeping the windows closed eliminates considerable pollen. The combination of air coolers with proper electrostatic filters is expensive but quite helpful. If the patient is dust sensitive the environment should be made as dust free as possible by the elimination of carpets, drapes, overstuffed furniture, comforters, feather pillows and dusty mattresses. I prefer that the pillows and mattresses be covered with duPont casings or other suitable materials rather than the substitution of rubber foam, cedar or kapok fillings.

The injection of specific pollen, dust or mold, aqueous (or alum-precipitated pyridine) extracts, over a sufficient period can produce satisfactory control in about 80 per cent of patients with these sensitivities. Depository injections of mineral oil emulsions are not recommended.

Symptomatic Treatment

The symptomatic treatment of both intrinsic and extrinsic asthma is similar. Theophylline epinephrine, ephedrine and synthetic ephedrine analogues, iodides, terpin hydrate, corticosteroids orally and parentally, Adrenalin chloride solution 1:100 (Parke Davis), Norisodrine sulfate (Abbott) or isoproterenol (Isuprel hydrochloride, Winthrop) may be used as an aerosol. If infection is present broad spectrum antibiotics are preferable unless specific sensitization culture studies indicate otherwise. In status asthmaticus especial care of the fluid and electrolyte balance is important. Sedatives such as chloral hydrate, Phenergan (Wyeth) or Atarax (Roerig)

are preferred to the barbiturates. Oxygen therapy should be used cautiously and the blood acid balance controlled if prolonged use is necessary. In cases otherwise not controlled, ether in olive oil per rectum may be tried. Meperedine (Demerol) (Winthrop) in small doses is permissible if the patient is exhausted, but under no circumstances should morphine be used. Enzymes intramuscularly or orally occasionally seem to be of value. Positive pressure therapy offers a useful way to use aerosols of bronchial dilators. It is a good psycho-therapeutic agent but in asthma is probably no better than other forms of administering aerosols. The asthmatic patient usually can inhale adequately but is unable to exhale sufficiently. Wetting agents may cause lakeing of the bronchial secretions and also inhibit ciliary action. Some of these are alkaline and may be contraindicated if there is accompanying emphysema and alkalosis.

When status asthmaticus is relieved epinephrine and aminophylline may again be resumed if indicated. The continuous use of epinephrine has not been shown to cause heart damage. For longer acting effects Sus-phrine (Brewer), an aqueous suspension of epinephrine or Bronkephrine hydrochloride (Breon) may be given subcutaneously and are preferable to adrenalin in oil (Parke Davis) which is less predictable in action and must be given intramuscularly. The antihistamines may produce dryness and are of value in asthma only when antiemetic or tranquilizing effect is desired.

A.C.T.H. and cortico-steroids are of great value but should be gradually discontinued as soon as the asthma can be controlled by more routine methods. If the asthma remains intractible and controlled by no other drug, the smallest effective dose should be given and sufficient supplementary electrolytes given to avoid calcium or potassium deficiency. In some instances the use of aerosols of Dexamethasone 21-phospate (0.0 mg. per measured dose) by means of Respihaler Decadron (Merck, Sharp and Dohme) or in combination with 0.1 mg. isoproterenol sulfate, Respihaler ProDecadron (Merck, Sharp and Dohme) provides sufficient cortisone therapy with minimum likelihood of deleterious effects.

Chronic bronchitis may co-exist with asthma and long or short term therapy preferably with broad spectrum antibiotics may be indicated.[5]

Just as pulmonary emphysema and bronchitis are not infrequent complications of allergic asthma, hypersensitive disease occasionally may be found in chronic lung disease when least expected. Screening skin tests to ragweed, grass, house dust and mold should be done as routinely as tuberculin, and histoplasmin tests are made in the differential evaluation of chest diseases.[6]

Conclusion

Allergy should be considered in the etiology of all chronic chest disease. The chest physician should familiarize himself with the techniques of allergic diagnoses and treatment which could prove valuable allies in his practice. He could perhaps more easily add these to his therapeutic armamentarium than could members of other less related specialties. Simple screening skin tests offer an excellent mode of differential diagnosis in perhaps 90% of allergic chest conditions. When allergy is an important factor the chest physician could either refer these patients for more complete study or prepare himself with adequate training to assume total care of his patient.

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CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Epinephrine Overdose

CASE report—This 14-year old white male was admitted to the hospital on the 14th of December 1962 for revision mastoidectomy, right.

Past History: The patient had been in good health except for chronic otitis media in the right ear for nine years prior to admission.

Previous Operations: Simple mastoidectomy, right, 4 months prior to the present admission.

Physical examination: revealed a normal 14 year old boy with a draining right ear. Lungs were clear to percussion and auscultation. The heart showed normal sinus rhythm and there were no murmurs or thrills. Blood pressure 125/80, pulse 90, temperature 98.6° F., weight 102 lbs., and height 63".

For pre-anesthetic medication the patient received pentobarbital 120 mg. and atropine 0.3 mg I.M. at 0630 hours on the 18th of December. When he arrived in the operating room he was drowsy and cooperative. His blood pressure was 120/50, and his pulse 80/min., prior to induction of anesthesia.

Anesthesia was induced at 0745 hours using nitrous oxide, oxygen, ether sequence. The trachea was intubated with a #32 Fr. cuffed orotracheal tube which was connected directly to the rebreathing system. The anesthetic mixture was changed to nitrous oxide, (4 L/min.) O_2(2L/min.) and methoxyflurane in a semi-closed CO_2 absorption system. Blood pressure immediately following induction and intubation was 140/60, pulse 92, respirations 32 and regular. The blood pressure reached a plateau between 120 and 110 systolic and 50 diastolic, the pulse remaining stable at 92/min. Spontaneous respirations were regular and of adequate depth. The site of operation was prepared and draped.

At 0830 hours the surgeons were in the process of injecting, in the region of the mastoidectomy scar, what was thought to be a local anesthetic solution containing 1:50,000 epinephrine. The solution instead was 1:1,000 epinephrine. Approximately 2.5 cc (2.5 mgm) were injected and the patient immediately developed a tachycardia of over 200 per minute and the blood pressure was measured at 220/120 mm Hg. Within three more minutes the patient developed pulmonary edema and a gallop rhythm. Anesthesia was discontinued and the rebreathing system flushed with 100% oxygen at high flow. The blood pressure within ten minutes after the injection of epinephrine had returned to 170 systolic where it remained for 20 minutes. Within 30 minutes of injection the blood pressure had returned to 110/70 but the pulse remained 120/min. The pulmonary edema had been treated by continuous positive pressure oxygen and the lungs were essentially clear to auscultation within 30 minutes of the injection of the epinephrine.

The patient was returned to the recovery room at 0930 hours without the operation having been performed. The first blood pressure taken upon his arrival in the recovery room was 70/30, pulse 120. Oxygen was administered by nasal catheter. Positive pressure oxygen by mask could not be maintained as the patient objected to the mask. Methoxamine (40 mgm) was added to the intravenous infusion of 500 ml. of glucose 5% in distilled water. A portable chest x-ray and an EKG were taken. The patient was coughing up bloody, frothy sputum and there were coarse rhonchi and fine rales throughout both lung fields. The chest x-ray showed evidence of moderate pulmonary edema.

A consultation with the Department of Car-

diology was obtained. Digitoxin 0.6 mg. was administered at 1120 hours and an additional 0.4 mg. at 1200 hours on the 18th of December. By 1400 hours the pulse rate had slowed to 100/min. The patient at this time was nauseated and had vomited several times. In the evening of the day of proposed operation his pulse rate again climbed to 138 per minute, respirations ranged between 40 and 56 per minute but had returned to near normal by the following morning. He was returned to the ward at 0830 hours on 19 December.

Upon return to the ward he was again seen by the consultant in Cardiology. At this time examination revealed pulse 124 regular, blood pressure 95/60, respiration 24 and regular, temperature 97° F. (oral). The patient was in no acute distress and neither cyanosis nor distended neck veins were visible. The lungs were clear to auscultation and percussion. The heart showed no cardiac enlargement and no thrills were palpated. There was, however, a diastolic gallop rhythm and a Grade II soft systolic murmur at the left fifth interspace at the sternal border.

The EKG taken shortly after return to the recovery room on the 18th of December had revealed sinus tachycardia and right axis deviation and high P waves in chest leads V 1-3. The EKG taken at the time of the cardiologist's visit on the 19th showed a persistent sinus tachycardia and right axis deviation. No T wave changes were observed, but the P waves in the precordial leads had now become bifid. The cardiologist was in agreement that the episode of pulmonary edema was probably induced by the injection of epinphrine. The patient was placed on bed rest and a maintenance dose of digitalis. He was ambulated on the 21st of December and discharged from the hospital on the 24th of December to be followed in clinic.

When seen in clinic on the 4th of January, his pulse was 80, respirations 18, and blood pressure 110/50. Examination of the lungs revealed no adventitious signs. The heart showed a Grade I diastolic murmur in the third interspace just to the left of the sternal border. The EKG showed evidence of right ventricular enlargement. On the 11th of January, the EKG was interpreted as suggesting some subacute pericarditis in addition to the right ventricular enlargement.

Following discharge from the hospital and in between clinic visits, the patient had two episodes of syncope which were thought to have been related to hyperventilation and to be associated with a weakness in the right upper extremity. An EEG taken at this time was interpreted as showing little dysrhythmia with no evidence of focal abnormality.

The patient was followed at weekly intervals in the Cardiology Clinic until the 1st of February and monthly thereafter. On the 1st of March his EKG still showed evidence of right ventricular hypertrophy. On the 3rd of May, the patient was found to be completely asymptomatic and had been on no medication for several months. The EKG at this time was interpreted as probably normal except for right axis deviation. No murmurs were heard upon examination of the heart.

Discussion

Eugene H. Conner, M.D., Professor and Chairman, Department of Anesthesiology, University of Louisville, School of Medicine.

The first point for discussion concerns the pharmacologic actions of epinephrine in normal man.

Physiological responses to infusions of *l*-epinephrine (of synthetic origin) in man have been variously reported by different investigators. The conflicting reports appear to be related to the total dose of epinephrine administered and the concentration and rate of infusion. L-epinephrine infusions will result in vasodilatation only in skeletal muscle. The vascular beds of the skin, kidney, and pulmonary circulation, are constricted. There is a rise in systolic and decrease in diastolic blood pressure, although there is only a slight rise in mean arterial pressure.

Of equal importance is the action of epinephrine on the heart. It is a powerful cardiac stimulant, infusions of 0.15 to 0.3 micrograms/Kgm /min. in normal man has been observed to nearly double the cardiac output.[4] There is a marked and sustained increase in heart rate —chronotropic effect. Epinephrine will produce ectopic ventricular foci and there may also be premature auricular or nodal beats. Ventricular extra systoles may be so numerous as to result in ventricular fibrillation.[5, 6]

In the presence of certain hydrocarbon or halogenated hydrocarbon anesthetics, epinephrine will produce ventricular fibrillation. This phenomenon is well documented for

chloroform, cyclopropane, and halothane. Although methoxyflurane (2, 2-dichloro-1, 1-difluoroethyl methyl ether) is a halogenated anesthetic, it may be used when epinephrine is being administered, since it does not predispose the heart to ventricular fibrillation.[7] Although ventricular fibrillation has been produced in the dog,[8] this property of compatibility with epinephrine is apparently related to the presence of the ether linkage.

The mechanism of cardiac failure without significant ventricular arrhythmia is probably related to the rapid heart rate and to the brief period for diastolic filling. An alternative explanation is suggested by the significant rise in pulmonary arterial pressure which may reflect an increase in left atrial pressure or pulmonary vasoconstriction. The sustained rise in pulmonary arterial pressure and the rapid rate would soon result in breakdown of the balance between oncotic and hydrostatic pressure in the pulmonary capillary bed. The most obvious indication of failure is the rapid onset of pulmonary edema.

The duration of action or biologic half-life of epinephrine should be considered. Epinephrine, whether of endogenous or exogenous origin, has a prolonged period of action. This is in contradistinction to *l*-nor-epinephrine, which has a short duration of action. When an infusion of *l*-nor-epinephrine is discontinued, its effects are abolished within 1 or 2 minutes. Epinephrine's action is sustained for over 30 minutes.

The treatment of choice in this case is continuous positive pressure respiration until the action of epinephrine has disappeared. The use of Digitalis is of doubtful importance in the management of pulmonary edema which is produced by the action of epinephrine in a normal heart.

The possibility of treating an overdose of epinephrine with an adrenolytic agent should also be considered. The action of epinephrine on the heart (tachycardia) is caused by stimulation of the beta receptors.[9] All of the presently available adrenolytic agents block alpha receptors. There are several beta receptor blockers that have been studied[10, 11] and they will block the cardiac effects of epinephrine. Unfortunately, neither is available for clinical use.

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November 14-20, 1965

Diabetes Detection and Education Drive

Your Participation

Is Important



Kentucky Physicians' View of Medical Education†

ROBERT STRAUS, PH.D.*

Lexington, Ky.

As one step of an effort to develop stronger ties between the practicing physicians of Kentucky and the state's two medical schools, the Council on Medical Education and Hospitals of the Kentucky Medical Association, in June 1964, distributed a questionnaire on medical education to the state's approximately 2700 physicians.

This report is a summary of information provided by the 720 Kentucky physicians who returned completed questionnaires. For purposes of analysis, respondents have been divided into three groups; those from Jefferson County and those from Fayette County, sites of the state's two medical schools, and those from the rest of Kentucky. The proportion of respondents to total physicians in these three areas was virtually identical — roughly 27%.

A basic question concerned the degree to which respondents felt informed about such aspects of medical education as curriculum, methods of teaching, and the place of research in relation to education. A majority of the respondents (three-fifths) indicated that they felt moderately well informed on these matters and one out of five reported that they were well informed. The other fifth reported having little or no information. As might be expected, the vast majority of those feeling well-informed were from Jefferson and Fayette Counties.

In response to the question, "Based on your experience and current observation, are there areas of medical education on which you would like to see greater emphasis?", there were 427 suggestions. Eighty-eight of these called for a greater emphasis on general or family practice. Running a close second were eighty-four suggestions for more attention to the community, social and economic aspects of medicine. Fifty-one suggestions cited common practical aspects of medical practice, while there were thirty recommendations for more emphasis on psychiatric, emotional, and mental health topics. When the same question was phrased in terms of "lesser emphasis" there were only seventy-three responses, half of which suggested less emphasis on research.

A substantial number (72 per cent) of the respondents reported that they had attended programs of postgraduate medical education during the past three years. Thirteen per cent of these reported attending programs conducted by the University of Louisville, 15 per cent by the University of Kentucky, and 20 per cent by either Louisville or Kentucky, or both, together with programs by medical schools in neighboring states. Eighty-six per cent of the respondents reported the postgraduate education programs which they had attended had been very beneficial, thirteen per cent reported these programs interesting but of no special educational value, and only one per cent reported that the programs had been of no benefit to them at all. When asked whether they would like to attend more postgraduate courses if these were made available in Louisville, Lexington, or "their own area" respondents showed a striking variation of opinion. A number of comments from Jefferson County and Fayette County pointed to the difficulty of attending meetings at home without interruption and expressed a preference for out of town postgraduate courses. In contrast, most respondents from the rest of Kentucky cited the barriers

†*Based on a report to the Council on Medical Education and Hospitals of the Kentucky Medical Association prepared with the assistance of Clare W. Winslow, department of Behavioral Science, University of Kentucky Medical Center, Lexington.*

**Professor and chairman of the department of Behavioral Science at the University of Kentucky Medical Center.*

of time and distance and interference with practice when they had to travel far for postgraduate courses and expressed a marked preference for having such courses in their own areas. When asked to cite fields in which they would like to see more postgraduate educational programs, the largest number of respondents requested programs dealing with new diagnostic ideas, tests and techniques or with new drugs.

Physicians were asked how they perceived the role of a University hospital with respect to medical practice in the community. The most frequently cited roles were as centers for referral and consultation, for the handling of difficult or problem cases, and for locating special facilities. Other comments referred to a University hospital as a source for leadership, the upgrading of practice, the setting of standards and the introduction of new methods. Most of the relatively few negative views expressed toward University hospitals came from physicians outside of Jefferson and Fayette Counties.

Respondents were asked their views concerning the role which full-time faculty members at medical schools should take in the activities of state and local medical societies. Two-thirds of those responding to this question indicated special contributions which full-time faculty could make to their medical societies, including participation in society programs, reporting on innovations in medical education and advances in research and sharing specialty knowledge and new methods of patient care. Many expressed the view that participation in medical society affairs would provide faculty members with an opportunity to understand and appreciate the problems of private practice.

Comments regarding the relationship between the medical school faculties of the two universities and practicing physicians in the state covered a broad range of impressions ranging from excellent to poor — from improving to deteriorating — from placing blame for problems on faculty to placing blame on practicing physicians — and from suggesting that more practitioners should teach to suggesting that more faculty should practice. Generally, positive impressions far outweighed negative ones.

Summary: The opinions of Kentucky physicians on medical education, as summarized in this report, reflect a strong interest and concern for medical education on the part of the majority of the respondents to this study. It cannot be determined to what extent respondents may differ from non-respondents on this matter although interest could certainly be a significant factor motivating the self-selection of physicians who returned the questionnaire.

The 720 physicians who responded to the questionnaire were interested, vitally concerned, and they provided many thoughtful suggestions regarding the relationship between medical education and medical practice. There was perceived need for more postgraduate courses and other opportunities for continuing education and a clear recognition of a special need for and responsibility of University hospitals. While some responses reflect misunderstanding and conflict, the majority reflect appreciation, optimism and support for stronger bonds in the future between the medical schools and the practicing physicians of Kentucky.

Remember

Community Health Week Nov. 7 - 13

EDITORIALS

Report on Our Progress--Or Lack of It

WITH THE increasing complexities of life and practice the physicians' program of activities has undergone constant change during the past few decades, particularly since the end of World War II. The multiple and ever varying schedules of taxes has made it necessary for almost all of us to employ some type of financial advisor. It is unusual now that one undertakes to keep account of his own income, overhead, tax and social security obligations, as was the custom prior to 1940.

Registered nurses have become so scarce that the hospital care of patients is now fragmented into the duties of the oxygen therapist, the licensed practical nurse, the nurse's aid, and the candy striper. The secretarial work and charting requirements have been increased beyond the feasibility of being performed by the registered nurse as in the past, and the floor secretary, without medical or nursing experience or training, has come upon the scene.

Hospital management has passed almost entirely out of the hands of the physician in private and public hospitals, Veterans Administration facilities and even in the Armed Forces. The adequate training of hospital administrators in sufficient numbers to meet this demand has been a very fortunate development and none of us believe strongly that care of the sick has suffered from the exit of the physician-manager and the coming of the trained hospital administrator or hospital corps officer.

It has come to pass therefore in the changing pattern of things that many people in varying capacities now share the physicians' labors and responsibility. This has affected every phase of his work in the administration of his business, the care of his patients in the office and in the hospital. The change has not always been to the advantage of the physician nor to his patients, but apparently is a necessity because of the limitation of the individual physician's time and the lack of a sufficient number of physicians to go around.

In no phase of medical work has this change been more felt and more harmful than in the field of Public Health. Increased attractiveness of private practice, research and teaching have drawn many men who otherwise would have gone into the work of Public Health. This trend has been augmented to an appreciable extent by the limitation of salaries of Public Health Physicians. Due to its expanding functions and the decrease in the number of trained physicians available this medical activity has suffered to an unusual degree by encroachment of non-medical people.

We cannot disparage the importance of public health as a speciality. The prevention of disease, the control of epidemics, the maintenance of maternal and child health service, the provision of adequate and up-to-date laboratory services for all physicians in the state, where such services are not available locally, are functions that are of prime importance. These services accomplish more in the improvement of our health standards than the private practice of medicine alone could ever provide.

The Public Health Department of Kentucky has had a long and exceptionally fine record, having been established early and administered by outstanding pioneers in this field. It has long stood as an example and model for similar activity in the other states. The programs developed here and the manner in which they are carried out have served as most useful examples for the establishment of similar services in many other health departments including those of Puerto Rico, Hawaii, and Alaska, who have often used our health Commissioners as consultants.

We have had an exceptionally fine succession of Health Commissioners: Doctor J. N. McCormack, Doctor Arthur T. McCormack, Doctor Philip Blackerby, Doctor Bruce Under-

wood, and our present Commissioner, Doctor Russell Teague. Doctor Teague had his early public health training in Kentucky. He spent most of his professional life in larger activities outside the state, but returned here as Health Commissioner February 16, 1956. He has proved himself worthy of the high traditions of the Commissioners who have preceded him. With the transfer of the Headquarters from Louisville to Frankfort and the enlargement of laboratory and other facilities he has continued to keep Kentucky in the forefront in the matter of Public Health.

No one man, regardless of his capabilities, can run so large an activity individually and alone. Doctor Teague has suffered tremendously from the loss of physician personnel in many of the important divisions of his department.

The control of epidemics is one of the most important functions of Public Health. The devastating epidemics of yellow fever, typhoid fever, smallpox and cholera are important in our country only from an historical standpoint, but other diseases require skilled and diligent attention. Of greater significance now are the childhood diseases, rheumatic fever, encephalitis, and intestinal tract infections. Traditionally the Division of Epidemiology has been under the direction of a trained Epidemiologist but in recent years there have been long periods in which this important function was, and is now, directed by a non-medical person without adequate training or experience.

The Division of Medical Care has grown to such proportions with Public Assistance, Old Age Assistance, Indigent Medical Care and the Kerr-Mills Program that it has taxed the resources of its new and excellent director, Doctor William McBeath. He has some medically trained assistants, but not enough. With whom responsibility for administration of the new program of medical care under Social Security will rest has not yet been determined, but it will certainly require an increase of personnel.

The Divisions of Mental Health, Experimental Health and of Research are now without trained medical direction. Doctor Teague's Deputy Commissioner is not a physician nor medically trained.

No division of our Public Health has suffered more than individual counties. Physicians, where at all available, have often served only on a part-time basis and may have three to five counties under their supervision. It is very fortunate that the Governor allowed some relaxation in the retirement at the age of 65. Several valuable physicians well trained in Public Health have been able to continue in their post beyond the stated retirement age. Had this not been allowed we would surely have been more severely handicapped than we find ourselves at the present.

What remedy is there to these changes affecting our Public Health Department? One, of course, is the training of more physicians in all fields of medicine so that more will be available for Public Health work. The incentive for entrance into this field may well be increased by restoring to physicians the important key positions which the system may have to offer. This will require the appropriation of larger amounts of money to be available for adequate salaries. It would indeed be money quite as wisely spent and perhaps to much better effect in the maintenance of the health of our people than is presently being spent on some other programs.

The State Board of Health is a body composed of eight physicians, one dentist, and one pharmacist. These men are appointed by the Governor from candidates nominated by their respective organizations. The Board is an integral part of the Public Health organization, serving in an advisory capacity to the Health Commissioner and to the Governor. Additional duties include the control of Medical Licensure under regulations established by the Legislature in our medical practice act, and disciplinary action related to physicians. How well these functions are performed is a matter of personal opinion, but from our experience of 18 months on this body we feel that the Board discharges faithfully and with the best judgement possible its varied duties.

One function of the Board of Health is to appraise and advise concerning all health activities in the State. During the past few years there have been so many research, investigative, pilot and experimental programs initiated by various federal and other agencies in Appalachia and elsewhere that we have become somewhat lost and bewildered as to their purpose and accomplishments, but we will keep trying.

Licensure of physicians is a very important function, especially with the increase in the number of graduates from foreign schools who have come into the state for training or for employment. With as careful investigation and

screening as is possible mistakes have been made and some men inadequately trained or completely untrained have been accepted. Some states have vested their licensure supervision in non-medical boards—that change would seem inadvisable for us. Whether this function is continued by the Board of Health or by a special Licensure Board, it should certainly be under the direct scrutiny and supervision of physicians who are, or should be, most conversant with the problem.

Our actions, whether in the field of public health or in private practice, are always under close observation and criticism. Changes are inevitable—sometimes constructive and sometimes not. We need to be alert that we maintain the best possible health service and that we resist the factors that would render it otherwise.

SAM A. OVERSTREET, M.D.

Diabetes—A Challenge

DIABETES Mellitus has been clearly described in the ancient literature of Egypt, China, and India. The name diabetes, taken from the Greek word meaning to "run through", appears in a Greek work of the first century A.D. It has been little understood until very recent times. The development in the past few years of new drugs for treatment and new knowledge of the pathophysiology of the disease is exciting and challenging.

Although undoubtedly genetically transmitted as a simple autosomal recessive, chromosomal abnormalities have not yet been discovered. We now know that the initial defect is not in the production of insulin, at least in the maturity onset form of the disease. By use of immunochemical techniques, more than normal amounts of insulin are found in the blood, but "free" insulin is decreased. It is not known at this time whether the disease is due to excessive protein binding, excesses of insulin kinase resulting in faulty destruction of insulin, antagonism by synalbumen, or increased insulin inhibitors.

The concept of prediabetes has stimulated the development of methods of diagnosis and treatment to prevent later, overt diabetes. Improved methods of diagnosing other diseases which may produce hyperglycemia (such as Cushing's disease and pheochromocytoma) enable us to distinguish these diseases from true Diabetes Mellitus.

Vascular, neurological, and renal manifestations of diabetes are no longer considered to develop solely from poor diabetic control, since these may antedate overt diabetes.

Despite the discovery of insulin and oral hypoglycemic agents, the treatment of diabetes still calls for careful control of diet. At least 75% of these patients are obese. Rigidity of diet, however, may lead to rebellion and poorer control. The desires of the patient should be met when at all possible. "Brittle" diabetes at times means only brittle therapeutics.

November 14-20, 1965, the KMA will sponsor the fifteenth annual Diabetes Detection and Education drive. This is a public service project in the true tradition of our democracy. Every physician has the opportunity and responsibility to aid in this drive, which has already found 2382 previously undiagnosed diabetics in this state.

IRVING F. KANNER, M.D.

Of Towns and Gowns

PRACTICING physicians are, in a literal sense, the offspring of their parent medical schools, and why there should be any conflict of interest or lack of understanding between the two groups sometimes seems mighty hard to understand. All doctors recognize the basic need for a steady production of well-trained new practitioners, if medicine as a profession is to continue. This production requires good medical schools, and who in the world should support and cherish these schools if not us, the men in practice—the men whose

careers these very schools have made possible.

On the other hand, medical schools certainly exist mainly to produce doctors, and should not the schools' efforts to help and educate us extend beyond the granting of a degree? Can a medical school by definition be doing a good job if it wakes up some day and finds itself in a position opposing the needs and wishes of its graduates? It seems, at least to this writer, that our schools are so much a major part of our profession, and our profession so much a part of our schools, that any discussion of town-gown conflict is a bit absurd. We've got to work together; one group is part and parcel of the other.

Certain major changes in the past generation or so have affected this particular phase of medicine's internal environment, though, a great deal and require some physiologic adaptation. To be specific, the schools, have, in the interests of efficiency and better education, switched almost entirely from part time to full time staffs. This step has resulted in a more controllable and probably better overall educational process, but has had the side effect of cutting back on the lines of communication between schools and practitioners. Also we should point out that nearly all schools, and ours in Kentucky are no exception, receive the majority of their operating budget from Federal funds—eliminating or at least decreasing the cross-interests of economics between communities and schools. We can, and evidently must, live with these divisive influences, but they must be recognized, understood, and overcome by definite efforts from both segments of the medical community.

The Council on Medical Education and Hospitals of the K.M.A., recognizing a need for information in this field, distributed a questionnaire in 1964 to all K.M.A. members. Doctor Robert Straus has been kind enough to help us with an analysis of our replies, and we invite your attention to his interesting article, on page 789 in this issue of the Journal.

WALTER I. HUME, JR., M.D.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater leadership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

ORGANIZATION SECTION

Diabetes Detection Drive Set For Nov. 14-20 in Kentucky

All members of the Kentucky Medical Association are urged to participate in the 1965 Diabetes Detection and Education Drive by Irving F. Kanner, M.D., Lexington, chairman of the KMA Diabetes Committee. The drive will be held in Kentucky November 14-20.

The 15th annual drive is being sponsored again by the KMA in cooperation with the American Diabestes Association. The goal of the program, Doctor Kanner said, is the location and treatment of victims of the disease.

In 1964, a total of 103,248 free tests were made and 230 proven cases reported. More than 2,200 cases of diabetes have been found during the 14 previous drives. All Kentucky physicians are asked to take part in the program, and check urine samples free for the week of the drive. County medical society diabetes chairmen are requested to make complete reports following the drive to the KMA Headquarters office.

Annual Meeting to be Reported

Because the Annual Meeting this year is being held after the deadline for the October issue of The Journal, it was not possible to include reports of the meeting. The November issue will carry full coverage of the general aspects of the meeting. The December issue will, as always, include a digest of the proceedings of the House of Delegates meetings.

AMA Clinical Convention Set For Philadelphia Nov 28-Dec. 1

A comprehensive scientific program, new postgraduate courses, and special clinical workshops are some of the features of the American Medical Association's 19th Clinical Convention, Nov. 28-Dec. 1 in Philadelphia.

More than 300 physicians will participate in giving the four-day program of lectures, exhibits, motion pictures, color television, fireside conferences, and breakfast roundtables.

The convention is being held in cooperation with the bicentennial observance of the University of Pennsylvania School of Medicine, the Nation's oldest medical school.

An outstanding scientific program is designed to hold special interest for the practitioner. Some topics to be covered are: ulcerative colitis, gram-negative bacterial infections, a medical-surgical review of cardiovascular surgery, drug therapy in rheumatology, and cancer chemotherapy and preventive surgery.

James Z. Appel, M.D., Lancaster, Pa., AMA president, in speaking of the program, said, "It promises to be a stimulating four days, worthy of the busy physician's time. I urge every physician to take advantage of the educational opportunity represented by the clinical convention."

McDowell Home Cited in Ceremony As National Historical Shrine

In ceremonies scheduled to have been held September 29, the McDowell Home and Apothecary Shop at Danville was recognized by the U.S. Department of Interior as a National Registered Historic Landmark, Laman A. Gray, M.D., Louisville, chairman of the KMA McDowell Home Committee, announced.

A certificate and placque to that effect were presented to the Home by representatives of the Department, Doctor Gray said. A number of KMA officials and members of the Committee were invited to attend the ceremony, with representatives of other interested groups.

A registered National Historic Landmark is a site or building designated as possessing exceptional value in commemorating or illustrating the history of the United States. All of the landmarks together compose the Registry of National Historic Landmarks.

McDowell House is the home of Ephraim McDowell, pioneer Kentucky surgeon. The KMA McDowell Home Committee was instrumental in the restoration of the house, working in close alliance with the Kentucky Pharmaceutical Association, who restored the Apothecary Shop.

AMA House of Delegates Holds Special Session on Medicare

The House of Delegates of the American Medical Association held a special session October 2 and 3 at the Palmer House in Chicago to consider pertinent items relating to current problems incident to health care laws and pending legislation, according to Milford O. Rouse, M.D., Dallas, Speaker of the House.

The session was called following receipt of written requests from 37 delegates from one third of the constituent state associations, as provided in Chapter IX, Section 5 (D) of the AMA Bylaws, Doctor Rouse said.

A number of KMA officials, including delegates Wyatt Norvell, M.D., New Castle; J. Thomas Giannini, M.D., Louisville; and John C. Quertermous, M.D., Murray, attended the session.

KMA Board Creates Committee For Study of Medicare Law

A special ad hoc committee to study the operation of Public Law 89-97 (Medicare), and make recommendations to the KMA Board of Trustees, was established at the August 4 meeting of the Board of Trustees. The recommendation for the committee came from the Council on Legislative Activities.

The Executive Committee of the Board appointed Donald Chatham, M.D., chairman, Shelbyville; Gabe A. Payne, M.D., Hopkinsville, and George W. Pedigo, M.D., Louisville, to make up the three-man committee, at its August 26 meeting.

A preliminary meeting of the committee was scheduled to have been held on Sunday morning, September 19, with Russell E. Teague, M.D., Commissioner of Health for Kentucky, and William McBeath, M.D., director of the present medical care program. Edward T. Breathitt, governor of Kentucky, has named the Health Department as administrative agent of the law for the state.

Members of the committee attended a special orientation conference on PL 89-97 sponsored by the American Medical Association, on October 1 in Chicago.

Dr. Rowntree Attends Meeting Of World Medical Assn.

Gradie R. Rowntree, M.D., Louisville, chairman for Kentucky of the U.S. Committee of the World Medical Association, represented the state at the meeting of WMA in London September 19-25.



Doctor Rowntree

Doctor Rowntree, industrial physician for the Fawcett-Haynes Printing Corporation in Louisville, was a founding member of the U.S. Committee. A past president of the Industrial Medical Association of the United States and Canada, he has served for several years as chairman of the KMA Committee on Industrial Medicine.

He is a former president of the Jefferson County Medical Society and is a member of the Louisville and Jefferson County Board of Health, having served as chairman for nine years.

Southern Medical Assn. to Meet Nov. 1-4 in Houston

Physicians from 17 Southern states will gather in Houston November 1-4 for the 59th Annual Meeting of the Southern Medical Association, to be headquartered at the Rice Hotel, according to Sam A. Overstreet, M.D., Louisville, SMA Councilor for Kentucky.

All scientific sessions, which will include special symposia, color television, panel discussions, and meetings of all specialty sections, will be held at the Sam Houston Coliseum.

A number of well-known guest speakers from outside the area covered by the Association will participate in the informative scientific sessions planned for the meeting, Doctor Overstreet said.

Sidelights of the meeting will include a golf tournament, President's Luncheon and the dinner dance on President's night, alumni reunions, and entertainment for wives.

Ky. Blue Shield Officer to Speak At Annual Program Conference

Avil McKinney, Louisville, director of Hospital-Physicians' Service of the Blue Shield Plan of Kentucky, will take part in a panel discussion on "The Prevailing Fees Program" during the October 25-26 annual Program Conference of the National Association of Blue Shield Plans.

The program, which will be held at the Drake Hotel, brings together physician board members and executive heads of the various state Blue Shield Plans. The number of Board of Directors members who are KMA members, planning to attend the conference, was not known at the time of this writing.

Mr. McKinney's topic, "Professional Relations", will cover the various aspects of dealing with participating physicians in presenting the Blue Shield program. Mr. McKinney had a leading role in establishing the new Ford Program in Jefferson County.

Journal Staff Members to Attend SMJAB Conference in Chicago

Sam A. Overstreet, M.D., Louisville, editor of The Journal of KMA, will represent The Journal at the biennial conference of the State Medical Journal Advertising Bureau, Inc., to be held October 23 and 24 at the Drake Hotel, Chicago.

J.P. Sanford, managing editor of The Journal and a member of the Board of Directors of SMJAB, will participate in a panel discussion during the meeting.

The program, directed this year by Thad Moseley, M.D., editor of The Journal of the Florida State Medical Association, is designed as a workshop for both medical editors and lay editorial staff members of state medical journals.

Farm-City Week is Nov. 19-25

November 19-25 is National Farm-City week in Kentucky. All KMA members are encouraged to participate in the 11th annual observance designed to build better understanding and appreciation of the interdependence of farm and city people throughout the state.

Farm-City Week provides the opportunity for farmers and city people to become better acquainted and to realize the problems of each other and to work toward their solution. Each KMA member is urged to take an active role in the joint visits, seminars, pageants, fairs, civic and social events planned for Farm-City Week.



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U. of K. College of Medicine Holds First Faculty Retreat

Carlisle V. Dodson, M.D., Russellville, a member of the KMA Advisory Committee to the University of Kentucky College of Medicine, represented the Association at the Faculty Retreat held by the College September 17-19 at Cumberland Falls State Park.

The purpose of the meeting was to review and evaluate the curriculum of the medical school and to express views on developments for the future. Representatives of the faculty at various levels, the student body and the Fayette County Medical Society, also attended.

Similar reviews have been held previously, at departmental levels. However, this was the first meeting of such broad scope.

KAGP, Industrial Medical Assn. Joint Seminar Set for Oct. 21

Seven outstanding guest speakers will provide an educational and interesting program for the Seminar on Industrial Medicine scheduled October 21 in Louisville, according to Carroll L. Witten, M.D., Louisville, president of the Kentucky Academy of General Practice, which will co-sponsor the session with the Kentucky Industrial Medical Association.

Among the presentations scheduled for the Seminar, to be held at Stouffer's Louisville Inn, are the following, listed with the speaker:

"Practical Management of Eye Problems Common to Industry"—Malcolm A. McCannel, M.D., clinical assistant professor of ophthalmology, University of Minnesota; **"Recognition and Management of Dermatologic Problems"**—Harry M. Robinson, Jr., M.D., head, division of dermatology, University of Maryland; and **"Respiratory Diseases Associated with Industry"**—Arthur J. Vorwald, M.D., chairman, department of industrial medicine and hygiene, Wayne State University, Detroit.

Other papers to be presented include: **"Soft Tissue Damage"**—Hugh A. Johnson, M.D., plastic and reconstructive surgeon, Rockford, Ill.; **"Skeletal Damage"**—Irvin E. Hendryson, M.D., orthopedic surgeon, Denver, Colo.; and **"Management of the Malingerer"**—Jackson A Smith, M.D., chairman of the department of psychiatry and neurology, Stritch School of Medicine, Chicago, Ill.

Albert E. Ritt, M.D., St. Paul, Minn., past president of the American Academy of General Practice, will be the speaker for the luncheon.

New Government Agency Set Up

According to the Office for Dependent's Medical Care, Office of the Surgeon General of the U.S. Army, the Coast and Geodetic Survey and the Weather Bureau have been consolidated to form a new agency in the Department of Commerce. It is known as the Environmental Science Services Administration.

KMA physicians should note that the rights of authorized dependents of the Commissioned Corps of the new agency for medical treatment under the Dependent's Medical Care Program are not changed. In the event new identification cards are issued to all the commissioned officers of the former Coast and Geodetic Survey and their dependents, you will be advised. Until further notice, present identification cards are to be honored, according to the Office of the Surgeon General.

Psychiatry PG Course Planned

The department of psychiatry at the University of Louisville School of Medicine is offering a 16-week postgraduate course in psychiatry to physicians in the Louisville area.

The course, which began October 6, will be held weekly at the Louisville Area Mental Health Center, Norton's Infirmary, beginning at 7:00 p.m. This meeting is open to the medical community and will feature a speaker of distinction. Physicians wishing to enroll may call 584-2204 for further information.

Auxiliary Board to Meet Nov. 9

The Board of Directors of the Woman's Auxiliary to the Kentucky Medical Association will hold its annual Fall Board Meeting at the KMA Headquarters Office on November 9, according to Mrs. Robert J. Salisbury, Mt. Sterling, newly installed WA-KMA president.

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SAFETY AWARD. John J. Robbins, M.D., Louisville, center, chairman of the KMA Highway Safety Committee, recently presented the KMA automotive safety award to Blue Boar Cafeterias of Louisville, represented here by L. Eugene Johnson, left, president of the restaurant firm, and his son, Wesley S. Johnson, vice president in charge of personnel. The organization received the award for having achieved 100% seat belt installation in vehicles operated by its employees.

Rejectee Counseling Program Set

The office of Local Health Services will be in charge of the recently-established program for counseling and referral of all Selective Service candidates rejected by the Armed Forces for physical or emotional reasons, Russell E. Teague, M.D., Commissioner of Health for Kentucky, has announced.

Trained personnel will give rejectees information on community and area resources available for corrective treatment or rehabilitation. The program was established by recent legislation by Congress. Carl C. Spies, Jr., will be project coordinator.

U.S. Military Surgeons to Meet

The Association of Military Surgeons of the United States will hold its 72nd annual meeting at the Washington Hilton Hotel, Washington, D.C., November 15-17. A full scientific program has been planned for the two-day session.

McDowell House Sets Record

McDowell House at Danville, the home of Kentucky's pioneer surgeon Ephraim McDowell, set a record in visitors this summer, it was recently announced.

The Home, restored through the efforts of the Kentucky Medical Association, has as an added attraction this year the portrait of Doctor McDowell by John Davenport, which was returned to the house in July. Francis Massie, M.D., Lexington, was responsible for the return of the portrait from the Kentucky Historical Society in Frankfort.

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Many types of edema involving retention of salt and water.
Contraindications
Hypersensitivity, and most cases of severe renal or hepatic disease.
Precautions
Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects
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Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

OCTOBER

21 KAGP Symposium on Industrial Medicine, Stouffer's Louisville Inn, Louisville

NOVEMBER

3 Professor's Day, 8:30 a.m.-3:30 p.m. University of Kentucky Medical Center, Lexington

4-5 Hematology, Postgraduate Course, University of Kentucky Medical Center, Lexington

15-19 Postgraduate Course #7, American College of Physicians, Pathophysiological Basis of Therapeutics, University of Kentucky Medical Center, Lexington

DECEMBER

1 Professor's Day, 8:30 a.m.-3:30 p.m. University of Kentucky Medical Center, Lexington

16 Norton Memorial Infirmary Annual Postgraduate Seminar, on Medical and Surgical Diagnosis, Norton Infirmary, Louisville

JANUARY

5 Professor's Day, 8:30 a.m.-3:30 p.m. University of Kentucky Medical Center, Lexington

6 Neurology - Neurosurgery, Postgraduate Course, University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

OCTOBER

15-17 American Association of Medical Assistants, Annual Meeting, Roosevelt Hotel, New York City

15-19 American Heart Association, Americana Hotel, Bal Harbour, Florida

18-22 American Association of Public Health Physicians, Conrad Hilton Hotel, Chicago

18-22 American College of Surgeons Annual Clinical Congress, Dennis Hotel, Atlantic City, New Jersey

22-23 American Association for Automotive Medicine, Mayo Clinic, Rochester, Minn.

23-28 American Academy of Pediatrics, Palmer House, Chicago

27-29 American Cancer Society, Biltmore Hotel, New York City

29-30 Symposium on Common Problems in General Practice-Office Procedures, Mound Park Hospital Foundation, Florida Academy of General Practice, 16th Annual Scientific Session, St. Petersburg

30-31 Disaster Medical Care, 16th National Conference, Drake Hotel, Chicago

NOVEMBER

3-4 Recent Advances in Medical Treatment, Postgraduate Course, Cleveland Clinic, Cleveland, O.

5 International College of Surgeons, State Division, Urbana, Ill.

8-11 Western Hemisphere Nutrition Congress (AMA Council on Food and Nutrition), Edgewater Beach Hotel, Chicago

11-13 Cerebral Palsy, Postgraduate Course, Mound Park Hospital Foundation, St. Petersburg, Fla.

11-13 Inaugural Scientific Program of new Ancker Hospital, St. Paul, Minn.

12-13 Association of Clinical Scientists, Statler Hilton Hotel, Washington, D.C.

17-20 American Academy of Orthopedic Surgeons, Postgraduate Course on Treatment of Injuries, Marriott Motor Hotel, Dallas

22 American Cancer Society and National Cancer Institute, Symposium on Hodgkins Disease, New York Hilton Hotel, New York City

27-30 AMA Winter Clinical Conference, Las Vegas, Nev.

28 Medical Aspects of Sports, AMA National Conference, Benjamin Franklin Hotel, Philadelphia

29-Dec. 2 Postgraduate Course on Pulmonary Function in Health and Disease, New Orleans, La.

DECEMBER

7-9 Southern Surgical Association, The Homestead, Hot Springs, Va.

JANUARY

12-13 Ophthalmology, Postgraduate Course, Cleveland Clinic, Cleveland, O.

19 Vascular Surgery, Postgraduate Course, Cleveland Clinic, Cleveland, O.

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IN BRIEF:

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

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Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

Supplied: Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

NEWS ITEMS

Rondall H. Leslie, M.D., who graduated in 1964 from the University of Louisville School of Medicine, has started general practice in Salyersville. Doctor Leslie recently completed his internship at Floyd Hospital, Rome, Ga.

Z. C. Layson, M.D., Maysville, who has limited his practice to ophthalmology and otolaryngology during the 41 years he has practiced in that city, has retired from practice, it is reported. Doctor Layson, who graduated in 1900 from the Hospital College of Medicine in Louisville, has moved with his wife to Lexington.

Chris B. Foster, M.D., Glasgow, has been appointed a clinical instructor in surgery at the Vanderbilt University School of Medicine, it has been announced. An otolaryngologist, Doctor Foster is a graduate of the University of Louisville School of Medicine.

AMPAC Schedules Dr. Gardner

AMPAC (the American Medical Political Action Committee) has scheduled the following speaking engagements for its Board member from Kentucky, Hoyt D. Gardner, M.D., Louisville.

September 24 Doctor Gardner addressed the Montana State Medical Association at its President's Luncheon at Great Falls, Mont., on "Ain't Necessarily So". On October 5 he spoke before the Sedwick County Medical Society (Wichita, Kan.) on "Challenge and the Opportunity". His topic February 27 at the interim meeting of the Tennessee State Medical Association at Nashville will be "Doctors and Politics—What Else?"

KMA Council and Committee Reports

KMA Technical Advisory Committee on Indigent Medical Care

Claude C. Waldrop, M.D., Williamstown, Chairman

KMA Headquarters Office **August 11, 1965**

The KMA Technical Advisory Committee on Indigent Medical Care met on August 11, 1965 in regular session. The Committee gave careful consideration to possible revision of the approved drug list, possible implementation of a credit card type of identification mechanism for each qualified client of the Kentucky Medical Care Program, and simplification of the prescription form, now in use.

Ky. M.D. Speaks in Rome

Thomas R. Marshall, M.D., associate professor of radiology at the University of Louisville School of Medicine, presented a paper entitled "Osteoarthropathies of the Hand" before the International Congress of Radiology in Rome, held September 22-28.

Dr. Kuhns, Harlan, Retires

Dwight M. Kuhns, M.D., pathologist and director of laboratories at the Harlan Appalachian Regional Hospital, resigned on August 1 for personal reasons. Doctor Kuhns, former deputy director of the Armed Forces Institute of Pathology, came to Harlan in 1956 following his retirement from the Army after 27 years of service. He was graduated from the University of Louisville School of Medicine in 1929. Doctor Kuhns was one of the Distinguished Guest Speakers at the 1951 KMA Centennial Meeting.

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23,000	1975	4¼	4.05	101.65
5,000	1976	4¼	4.10	101.33
24,000	1977	4.40%	4.20	101.89
25,000	1978	4.40	4.25	101.50
21,000	1980	4½%	4.35	101.65
25,000	1982	4.60%	4.50	101.18
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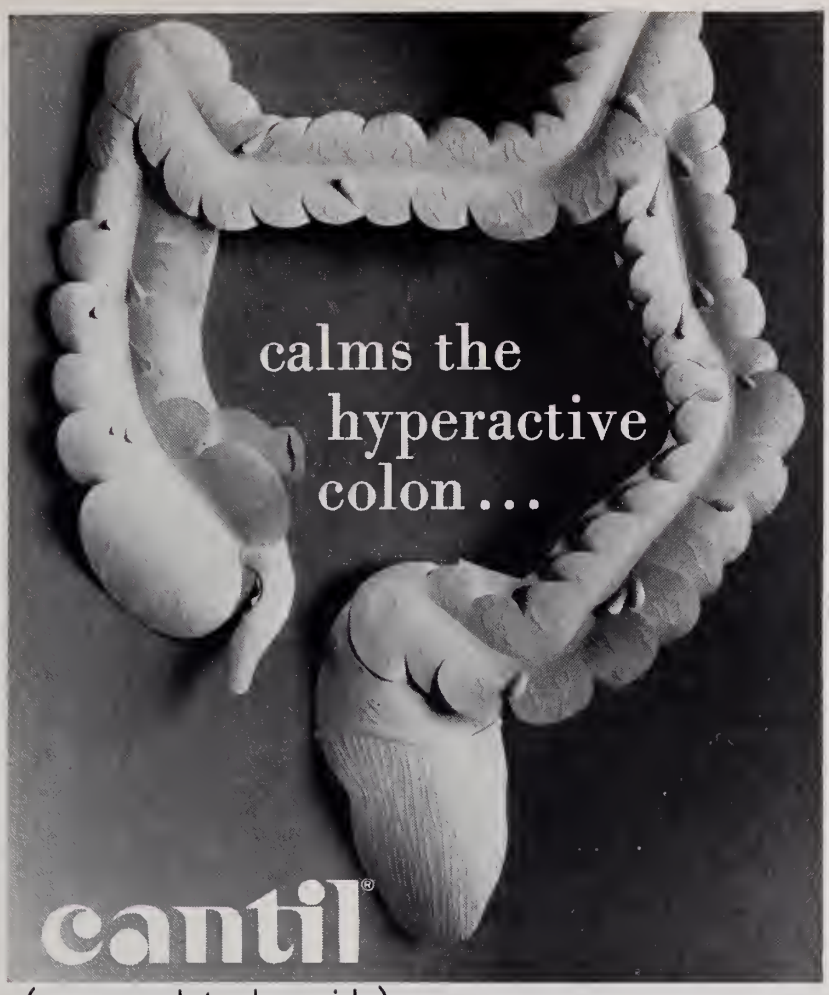
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IN BRIEF:

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1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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Dr. Brockman Speaks To Press

George F. Brockman, M.D., Greenville, addressed the Western Kentucky Press Association on "How Doctors and Newsmen Cooperate", at the fall meeting of the WKPA at Pennyrile State Park September 17. Doctor Brockman, speaker of the KMA House of Delegates, is former chairman of the Advisory Committee to the Editor of The Journal of KMA.

Two Ky. M.D.s Elected by FPA

Francis X. Sommer, M.D., Barbourville, was elected to a one year term as a vice-president, and George M. Gumbert, M.D., Lexington, was re-elected secretary of the Flying Physicians Association during its annual meeting August 22-27 at Miami Beach, Fla.

McConnell to Head City Chamber

J. Ed McConnell, Louisville, assistant executive director of Blue Shield and vice president of Blue Cross of Kentucky, was elected September 9 as president of the Louisville Chamber of Commerce, and will take office January 1. He is a member of the State Mental Health Planning Commission.

Student Essay Contest Announced

The American College of Chest physicians has announced its 1966 Essay Contest for undergraduate medical students on any phase of the diagnosis and/or treatment of chest diseases (heart or lungs). Three prizes of $500, $300 and $200 will be awarded. For information contact Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill., 60611.

Fetal and Neonatal Jeopardy

(Continued from Page 775)

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11:47 pm 11:53 pm 12:06 am

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Metahydrin® (trichlormethiazide) 2 mg. or 4 mg. Reserpine 0.1 mg.

In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.
Supplied: Metatensin tablets, 2 mg., 4 mg. — bottles of 100 and 1000.

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Each tablet contains:			
ACHROMYCIN® Tetracycline HCl	125 mg	Caffeine	30 mg
Acetophenetidin (Phenacetin)	120 mg	Salicylamide	150 mg
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Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects include drowsiness, slight gastric distress, anorexia, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation), photodynamic reaction to sunlight and increased intracranial pressure (in young infants). Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals. Patient should avoid direct exposure to artificial or natural sunlight; and should not drive a car or operate machinery while on drug. Reduce dosage in impaired renal function. Stop drug immediately at the first sign of adverse reaction.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y. Lederle

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WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: **ACTIONS AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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imferon®

(iron dextran injection)



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In Memoriam

MINOR B. PAYNE, M.D.
Hazard, Ky.
1903-1965

Minor Bransford Payne, M.D., Hazard general practitioner, died August 8 in Louisville after a prolonged illness. Doctor Payne, who was elected Hazard City Commissioner two years ago, was very active in civic affairs, as well as a number of medical organizations, including KMA. A native of Virginia, he graduated in 1929 from the University of Virginia College of Medicine and had practiced in Hazard since 1933.

EDWARD BOSS, M.D.
Louisville, Ky.
1875-1965

Edward Boss, M.D., Louisville, a general practitioner there for more than 55 years before his retirement in 1962, died August 5 at the Louisville VA Hospital. He was 90 years old. Doctor Boss, a veteran of the Spanish American War, was graduated from the Medical Department of the University of Louisville in 1897.

CLEMENT B. GETTELFINGER, M.D.
Louisville, Ky.
1895-1965

Clement B. Gettelfinger, M.D., 70, a general practitioner in Louisville for 33 years, died August 26 at a Louisville Hospital. He had retired from practice in June because of illness. Doctor Gettelfinger, who graduated in 1927 from the University of Louisville School of Medicine, practiced at Virgie, Ky., before coming to Louisville. Among his survivors are two brothers, Wilfred C. Gettelfinger, M.D., and Ralph A. Gettelfinger, M.D., both of Louisville.

ARTHUR L. GOODMAN, M.D.
Louisville, Ky.
1923-1965

Arthur L. Goodman, M.D., 42, Louisville general practitioner, was killed September 10 in the crash of the airplane which he was piloting. The accident occurred near Bowman Field in Louisville. A member of the KMA Governmental Medical Services Committee, Doctor Goodman was graduated in 1952 from the University of Louisville School of Medicine.

HARRY E. McCORD, M.D.
(formerly Ludlow, Ky.)
1884-1965

Harry Elliott McCord, M.D., who practiced general medicine in Covington and Ludlow for 42 years, died August 16 at Mattoon, Ill. Doctor McCord, who retired 16 years ago, maintained a summer home at Gays, Ill. A 1907 graduate of the University of Cincinnati College of Medicine, he was active in a number of medical groups.

In The Books
(Continued from Page 764)

non-specialist into highly technical and complicated areas in which he would rarely become involved.

The illustrations are excellent and derived in many instances from the most recent work in such areas as electron-microscopy, for example. The tables also are clear-cut and in keeping with the most recent thinking in the areas discussed. The section on pharmacology is unusually good, as are the sections on injuries and systemic diseases.

In summary, this work is indeed new in concept and design and presents a great amount of material which is readily understood. In addition, an excellent bibliography is given at the end of each chapter so that the reader may further pursue his studies.

RODERICK MACDONALD, JR., M.D.

Maternal Mortality
(Continued from Page 754)

This patient's protocol illustrates the problems posed by the complications of criminal abortion. The Committee classified the case as a direct obstetrical death with preventable features, principally indicting the patient herself for allowing instrumentation by an abortionist, but also criticizing the attending physicians, whose management of the well-defined picture of septic shock was not as vigorous and intensive as the recent literature on the subject has proved to be necessary. The definitive diagnosis of uterine perforation was only made possible by the autopsy, without which the basic nature of the fatal process would have remained in doubt. The Committee commended the attending physician for requesting permission for the autopsy, even though limited to the abdomen; in this instance, the limited examination was entirely sufficient to establish the definitive cause of death.

Blue Shield-Blue Cross Favored

Ten of the 11 "All-America" cities named for 1964 by LOOK magazine provide Blue Shield-Blue Cross Coverage to all or a portion of their municipal employees, according to a recent news release from the National Association of Blue Shield Plans. Hopkinsville, Ky., was one of the 11 cities selected by the magazine.



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*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

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Milwaukee, Wisconsin 53201

IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

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Now, ready? The answers may surprise you. The United States led all the rest with an amazing total of 369 drugs; Switzerland was next with 44, and Germany next with 33. Italy, a country without patent protection for the inventor, had 0. That's a research score Americans can well be proud of.

research quiz For two decades, three of these four countries have led the world in drug research. Of the 604 significant drugs discovered in the world during this period, how many do you think came from each country? (Answer above)



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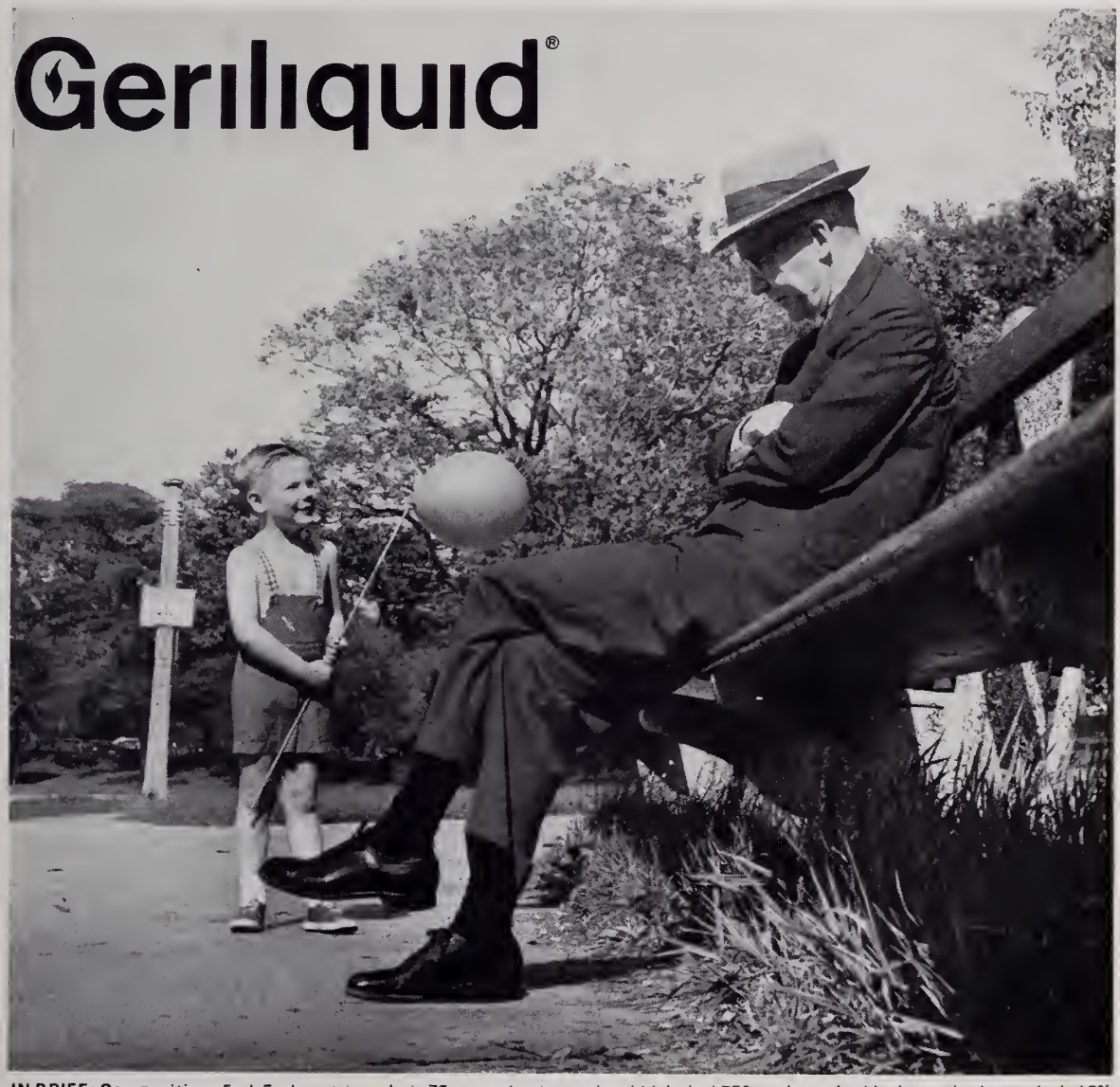
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Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.

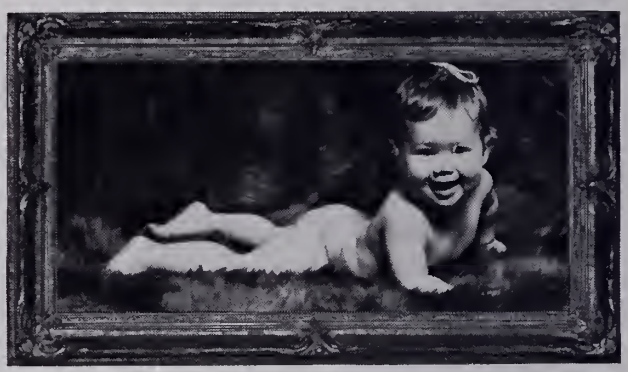
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Milwaukee, Wisconsin 53201



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1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957

2—Asher, L.M.: Am. J. Digestive Diseases *4*:272 (Apr.) 1959

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*Marks, V., and Dawson, A.: Brit. M. J. *1*:293, 1965.



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Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

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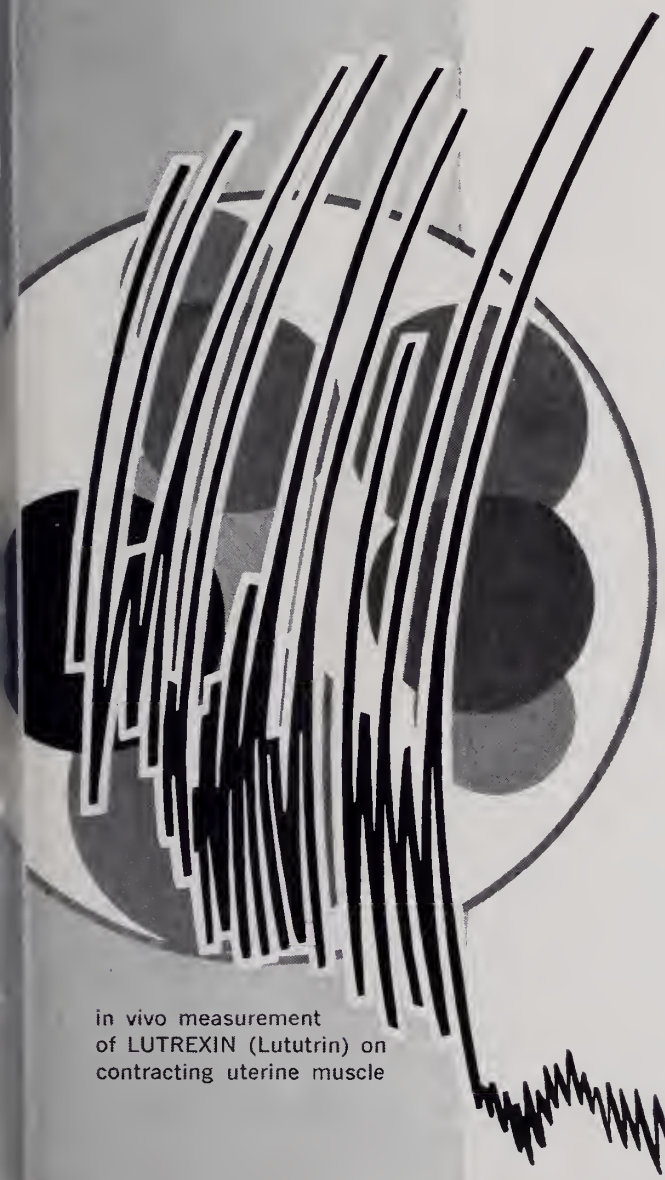
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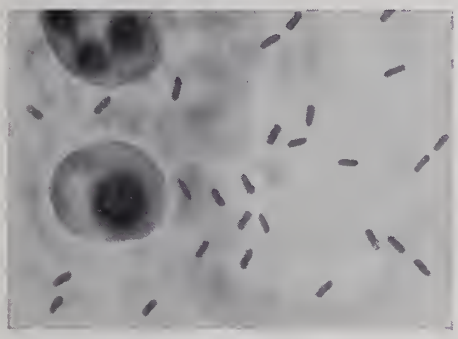
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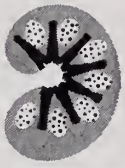
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to clear an infected stream





treat the source
with optimal dosage

NegGram®

Brand of
nalidixic acid

Treat the source. The gram-negative pathogens that cause most urinary tract infections. Treat them with a specific drug. NegGram. Clinical tests show that in adults two 500 mg. NegGram Caplets® orally four times a day will clear up most gram-negative urinary infections. Quickly...effectively...with minimal side effects.

Gram-negative urinary infection—cystitis, pyelitis, pyelonephritis, prostatitis, urethritis? Start first with NegGram..."a good 'starting' drug."[1] NegGram "...treatment may be first choice in potentially curable gram negative bacterial urinary infections."[2]

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1,000. **250 mg. for children,** available in bottles of 56 and 1,000.

References: (1) Carroll, G.: Urologists' Letter Club, June 1, 1964. (2) McDonald, D. F., and Short, H. B.: Address to the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, Oct. 26-28, 1964.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016

MESSAGE FROM THE PRESIDENT



KMA Dues

WHY are KMA dues greater than County Medical Society dues? This is a question that is asked by some members with pertinent discussion. The answer is simple. The KMA is involved in more activities on a broader basis and at a greater expense. Space permits us to touch only on a few of the more important points.

Our Kentucky Medical Association is recognized as one of the more progressive and effective of the small state groups. In order to accomplish this, we have to have an experienced and smooth working staff. We all recognize effective executive talent is not only necessary for a successful operation but in short supply.

Our executive secretary, Joe Sanford, is responsible for the overall operation, and for the implementation of all policies and programs. He staffs the House of Delegates, Board of Trustees, its Executive Committee, the Judicial Council, and the Annual and Interim Meetings. In addition he sees to the collection of materials for all departments of The Journal and publishing it on time.

Bob Cox, our assistant executive secretary, is Joe's "back-up" man—he staffs the Council on Scientific Assembly, which is responsible for the Annual Meeting scientific programs, writes the Communicator and other materials under appropriate supervision, manages the building and grounds and also staffs certain committees.

Tom Temple, our executive assistant, staffs four councils and most of the committees, promotes health education programs, Senior Day and accepts certain special assignments.

Gilbert Armstrong, our director of Field Services, staffs the Council on Legislative Activities (handles our lobbying in Frankfort), and the Rural Kentucky Medical Scholarship Fund, and other committees. All of these are hard working and spend many hours overtime in our behalf.

We also have, in addition to the secretarial staff, a comptroller, and a membership and an editorial assistant. Yes, carrying on effective and progressive programs for a 2225-member organization is a major operation. Your present KMA dues are a real bargain.

Everett H. Baker



BRING THE TREATMENT TOGETHER IN A SINGLE PRESCRIPTION

ACHROCIDIN®

Tetracycline HCl-Antihistamine-Analgesic Compound

Each tablet contains:			
ACHROMYCIN® Tetracycline HCl	125 mg	Caffeine	30 mg
Acetophenetidin (Phenacetin)	120 mg	Salicylamide	150 mg
		Chlorothen Citrate	25 mg

Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects include drowsiness, slight gastric distress, anorexia, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation), photodynamic reaction to sunlight and increased intracranial pressure (in young infants). Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals. Patient should avoid direct exposure to artificial or natural sunlight; and should not drive a car or operate machinery while on drug. Reduce dosage in impaired renal function. Stop drug immediately at the first sign of adverse reaction.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y. Lederle

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"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



The discomforts of

DIARRHEA
MUCOUS COLITIS
DIVERTICULITIS
SPASTIC URETERITIS
BLADDER SPASM

... are relieved by direct musculotropic action with

Trocinate®

BRAND THIPHENAMIL HCl

Available in 100 milligram pink sugar-coated tablets.

The high therapeutic index permits dosage sufficient to relieve spasm promptly. The usual initial dose is 4 tablets. Maintenance dosage is usually one or two tablets 4 times a day.

Trocinate *BRAND* THIPHENAMIL HCl

BETA-DIETHYLAMINOETHYL DIPHENYLTHIOACETATE HYDROCHLORIDE

... directly relaxes smooth muscle spasm
... combats hypermotility
... non-mydriatic – may be used in glaucoma

Trocinate (Thiphenamil HCl) has been found in three clinical studies, (J. Mo. Med. Assoc., 48:685-6; Med. Rec. & Annals, 43:1104-6; J. Urol., 73:487-93), to be effective and to be free of side-effects. Fifteen years of wide clinical usage has affirmed the safety and effectiveness of Trocinate.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856

Butazolidin® alka

Each capsule contains:

Butazolidin, brand of phenylbutazone	100 mg.
dried aluminum hydroxide gel	100 mg.
magnesium trisilicate	150 mg.
homatropine methylbromide	1.25 mg.

in painful shoulder



Geigy

Therapeutic Effects
The acute phase of subdeltoid bursitis, tendinitis and associated periarticular inflammation usually responds promptly and dramatically to phenylbutazone. Pain and tenderness may be relieved within 24-48 hours and mobility of the affected arm quickly restored. Full recovery is frequently achieved within 7-10 days so that therapy is generally of short duration. Calcific deposits are not specifically affected by treatment, but their presence does not appear to retard symptomatic improvement.

Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage
Initially, give 400 mg. daily (one capsule q.i.d), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. Butazolidin alka contains antacids and an antispasmodic to minimize gastric upset.

Note: The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

Also available:
Butazolidin®
brand of phenylbutazone
Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

BU 4010P



The Pain Is Gone

Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

'Empirin'® Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

Keeps the Promise of Pain Relief

BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.

IMPORTANT MESSAGE REGARDING CHILDREN WHO WILL SOON BE 19 YEARS OF AGE AND THEIR BLUE CROSS AND BLUE SHIELD PROTECTION



When children reach age 19, or marry before age 19, they are no longer protected under their family's Blue Shield and Blue Cross Plan. Instead, they must apply for their own INDIVIDUAL membership upon becoming 19 years of age, or for a FAMILY PLAN if they marry before age 19.

They should be sure to apply 60 days in advance for continuous Blue Shield and Blue Cross protection in their own name. The name and birthdate of the dependent along with the Subscriber's name, certificate number, and address should be sent to Blue Shield.

As a convenience, the coupon below may be used for applying.

MAKE SURE CHILDREN WHO BECOME 19 YEARS OF AGE HAVE CONTINUED PROTECTION WITHOUT ANY LOSS OF ACCUMULATED BENEFITS

MAIL THIS COUPON

FOR SURGICAL-MEDICAL PROTECTION

FOR HOSPITAL PROTECTION

To: Kentucky Blue Cross and Blue Shield
3101 Bardstown Road • Louisville, Ky. 40205

I wish to continue Blue Cross and Blue Shield on:

Name of Dependent

Who becomes 19 years of age _____
month day yeor

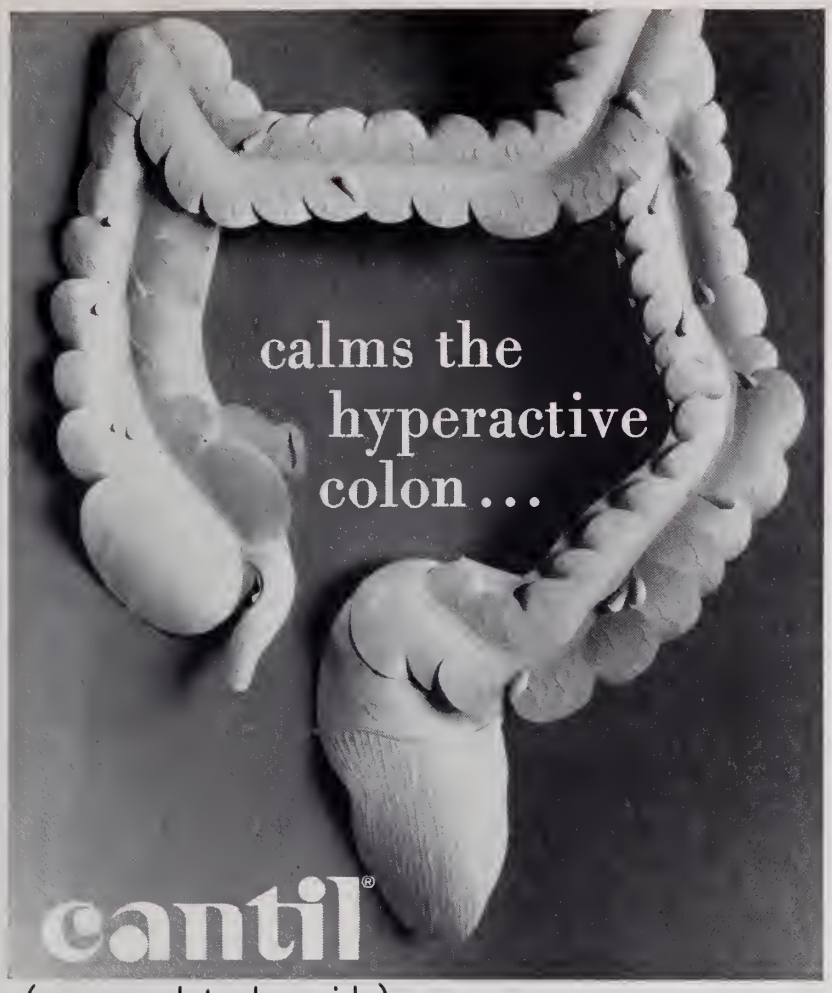
Please mail me an application so there will be no interruption of protection.

Certificate No. _____

SUBSCRIBER'S NAME _____

ADDRESS _____

CITY _____ KENTUCKY _____
Zip Code



(mepenzolate bromide)

helps restore normal motility and tone

Cantil (mepenzolate bromide) works in the colon. In irritable colon, spastic colon, ulcerative colitis and other functional and organic colonic disorders, it acts to:

- control diarrhea/constipation
- relieve spasm, cramping, bloating
- make patients more comfortable

with little effect on stomach, bladder or other viscera.

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250.

CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

PUBLIC HEALTH PAGE

Medical Attitudes in the Treatment of Alcholics

RUSSELL E. TEAGUE, M.D.

Commissioner of Health Commonwealth of Kentucky

IN THE MIDDLE of the morning of November 10, 1964, an Elizabethtown minister half-pushed, half-led a weak, trembling companion across the lobby of the Hardin County Health Department and asked to see, "the man from Louisville." The clerk, as she directed them to an office borrowed that day from the plumbing inspector, may have guessed that the minister's companion was sobering up from a long binge. What she did not know, however, was that the man had not been completely and thoroughly sober for more than eight years.

Later in the morning a woman hesitantly approached the desk and in a low voice said, "I understand there is someone here who will talk with me about my husband's drinking." At 4:30 that afternoon, after seeing four more people, the Rev. Roscoe J. Tarter thoughtfully picked up the book he had been advised to bring, "because you won't have anything to do" and went to thank the health officer for the use of the room before returning to Louisville. The first and lightest day he was to have in that office for the next nine months had ended.

Reverend Tarter is director of The Ministry to Alcoholics, a special service sponsored by the Board of Christian Social Concerns of the Methodist Church's Louisville Conference. His presence in the Hardin County Health Department that November day, and each Tuesday since, is a result of a community's willingness to recognize its alcoholism problem and accept it as a public responsibility.

Late in 1962, several members of Alcoholics Anonymous in Elizabethtown asked the State Health Department for assistance in stimulating local action for an alcoholism program. Several public meetings were held and from these a nucleous of interest emerged. This interest, which has since turned to dedication, was centered in members of a civic club which agreed to sponsor and help with the expense of a meeting place and part-time worker who would give assistance to alcoholics.

Although this plan did not prove to be the ultimate answer it did provide the community with an experience in working toward a solution to the problem and attracted the interest and participation of other influential people. In the spring of 1964, the Methodist Church in Elizabethtown invited Reverend Tarter to conduct a seminar on Alcoholism as a part of its lay education program. During a series of weekly meetings the participants came to the realization that alcoholism is an individualistic disease. The multiplicity of etiological factors and the difficulty of identifying them, the variance in the manifestations of the illness, and the wide range of approaches which succeed and fail make alcoholism highly resistant to the skills and efforts of any single person, group, or profession.

With this concept of a multi-disciplinary approach as a background the Hardin County Council on Alcoholism was organized by persons who had retained their interest in and concern for the alcoholism problem. They invited Reverend Tarter; C. E. Hernandez, M.D., county health officer; and the director of the State Health Department's Alcoholism Program to meet with them to plan a new and expanded program. During that meeting the Reverend Tarter volunteered to provide direct counseling services on a demonstration basis, and Doctor Hernandez offered space and other facilities at the Health Center. Later, when the beginning date was set, the radio station and newspapers gave more than ample publicity to the project.

Since that first day more than 200 persons have come to the Health Center seeking assistance for themselves or a person near them. Wives, husbands and employers form the largest group of non-alcoholics who come seeking information and advice. So far, thirty men and women who were unable to function because of their drinking are now employed and maintaining sobriety. This includes the man who had been intoxicated for eight years.

Doctor Hernandez attributes the success of the service to the fact that every community resource which he or Reverend Tarter have called on have responded positively. Physicians give necessary medical services and on occasion have arranged for hospitalization. Ministers have seen patients and their families who wanted spiritual guidance. The Hardin County Mental Health Center has accepted referrals. County and city courts and law enforcement agencies have cooperated. Public Health Nurses have made referrals and assisted with follow-up visits to families.

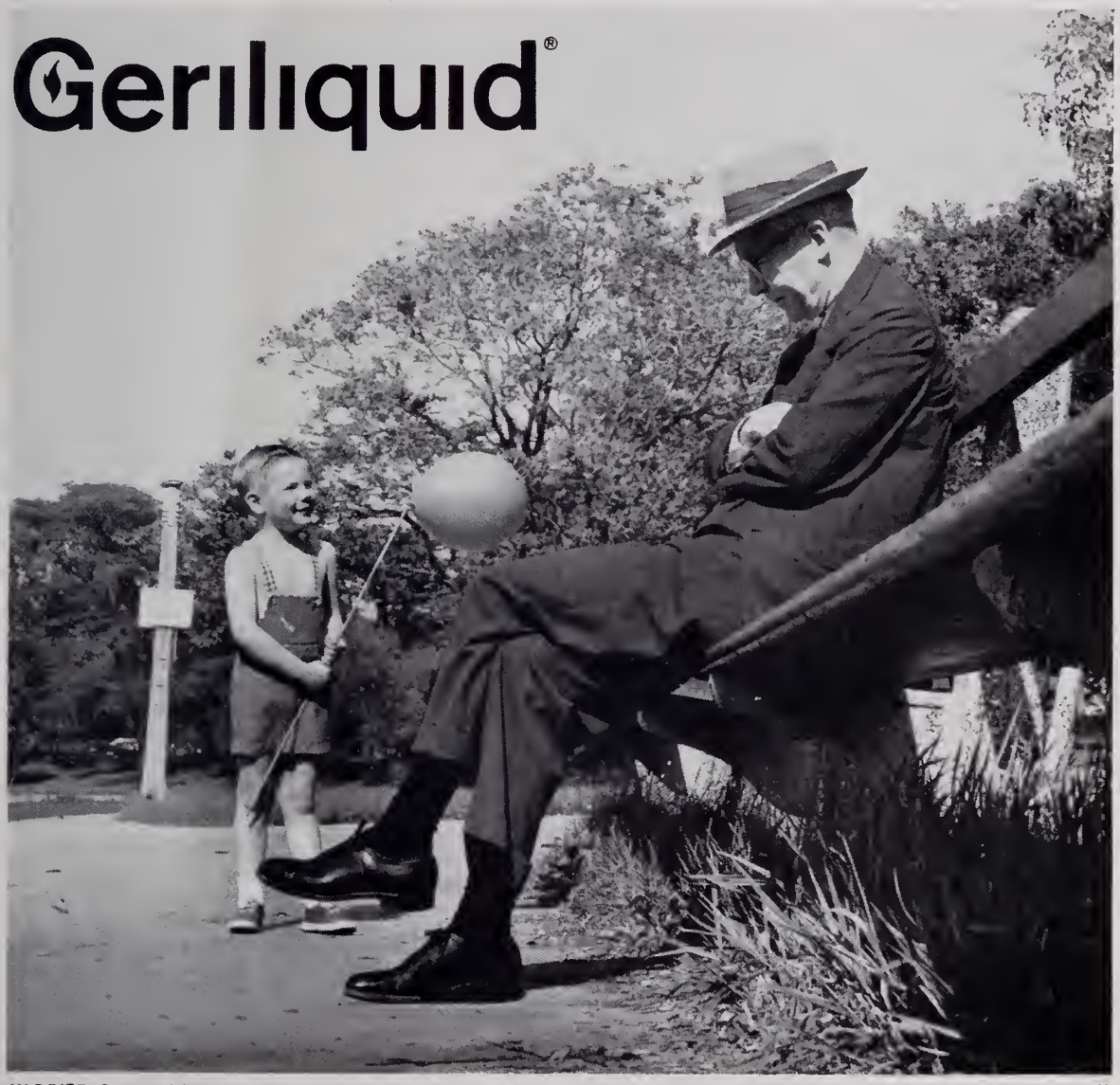
†This article was prepared by Omar L. Greeman, B.J., M.S.P.H., Director, Alcoholism Program, Kentucky State Health Department, 275 East Main Street, Frankfort, Ky.

when even southern sun fails to warm cold hands and feet

provide rapid, sustained vasodilation for warmth and relief of pain, dizziness and faintness in patients with impaired peripheral circulation

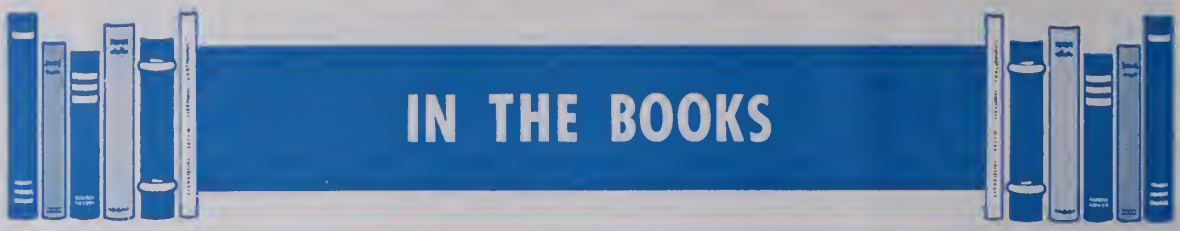
GERILIQUID warms cold hands and feet through the thermogenic action of glycine and through sustained vasodilation by glycine and niacin. In addition, in patients with impaired peripheral circulation, GERILIQUID increases the ability to walk farther with less pain. Patients particularly like the palatable, sherry wine base.

Geriliquid®



IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.
Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.
Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.
Supplied: Bottles of 8 oz. and 16 oz.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201



SURGERY OF THE PAROTID GLAND: by Robin Anderson, M.D., and Louis T. Byars, M.D.; Published by the C.V. Mosby Company, St. Louis, 1965; 172 Pages; Price, $12.75

"Were it not for the facial nerve, there would be little excuse for writing this book." This quotation from the text of this short book emphasizes that most of it concerns the crucially important facial nerve. The surgical anatomy, operative identification, surgical handling and reconstruction of the nerve are all ably described and summarized by two plastic surgeons who possess obvious ability and considerable experience. The facial nerve deserves the book, and all of us need repeated reviews of its surgical aspects and relations.

It is more of a monograph; the book is strong on illustrations, diagrams, "before and after" pictures, such as those showing degree of function after nerve grafting. The latter procedure is essential in modern parotid gland surgery, and it receives proper attention in the volume. The authors follow sound surgical principles, and they clearly defend sensible solutions to many technical dilemmas which have puzzled all surgeons from time to time: they do not favor needle biopsy in the parotid, do open biopsies only of tumors suspicious of being malignant; they discourage the use of an electric nerve stimulator, preferring the gentle hemostat; they favor immediate nerve grafts.

Whereas Doctors Anderson and Byars have had outstanding success with a somewhat indefinite and flexible operative approach to the facial nerve branches, we feel it might prove safer to *teach* routine exposure of the main facial trunk to the occasional parotid surgeon.

The chapter on pathology is generally sound, but consists mainly of a review of a few solid works in the field without new contributions. There is no discussion of new methods of nerve grafting, no complete review of the authors cases of malignant tumors of the parotid, both of which we would expect to find. The short chapter on radiation lays down some guides as to when to employ it; a few sentences about how to identify a competent radiotherapist and when to consult him would have done as well.

CONDICT MOORE, M.D.

SURGERY OF THE BILIARY PASSAGES AND THE PANCREAS: by Dr. Walter Hess. Translated from the German by Dr. Heinrich Lamm: Published by D. Van Nostrand Company, Inc., Princeton, N.J., 1965; 617 Pages; Price, $25.00.

This text represents an English translation of a German author. It covers in depth and great detail the anatomy, physiology, pathology and operative management of the gallbladder, biliary tree and pancreas. American terms for instruments and drugs are used thoughout.

The first half of the book is a good reference source for students, residents and academically inclined surgeons. In addition to extensive coverage of anatomy, physiology, and pathology, special attention is given to clinical and operative diagnostic procedures. The author feels that the classic means of exploration of the biliary tree fail to give consistently good results, especially in the discovery of stones and in recognizing organic or functional disturbances of the sphincter of Oddi. For this reason he strongly urges the use of radiomanometry, pancreatography and choledochoscopy at the operating table, as the indication may arise.

Of these, radiomanometry is probably relatively new to most American surgeons. The technique is well described and is a refinement of the standard operative cholangiogram. A manometer tube is attached by a Y connector to the choledochal cannula and the zero point centered at the level of the common duct. As the contrast medium is injected the pressure at which it traverses the biliary tract and sphincters is determined by x-ray or fluoroscopy. The author emphasizes that it is only by such pressure measurements that one can determine whether bile can traverse the sphincter under normal pressure or whether there are obstacles (organic or functional) that are overcome only by increased pressures.

The practicing surgeon will find the second part of the book most useful. Operative techniques are comprehensively covered in a step-wise fashion and well illustrated by artistic drawings. The author gives close attention to when to do specific operations.

E. TRUMAN MAYS, M.D.



more complete relief for the "dyspeptic"

DACTILASE®

Dactilase provides comprehensive therapy for a wide range of digestive disorders. Its antispasmodic and anesthetic actions rapidly relieve pain and spasm. Dactilase decreases hypermotility without inducing stasis. In addition, it supplies digestive enzymes to help reduce bloating, belching and flatulence. Dactilase does not interfere with normal digestive secretions. Very often it can be a most useful answer to the dyspeptic's needs.

DACTILASE: Each tablet contains: Dactil® (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylolytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

NOVEMBER

15-19 Postgraduate Course #7, American College of Physicians, Pathophysiological Basis of Therapeutics, University of Kentucky Medical Center, Lexington

DECEMBER

1 Professor's Day, 8:30 a.m.-3:30 p.m. University of Kentucky Medical Center, Lexington

16 Norton Memorial Infirmary Annual Postgraduate Seminar, on Medical and Surgical Diagnosis, Norton Infirmary, Louisville

JANUARY

5 Professor's Day, 8:30 a.m.-3:30 p.m. University of Kentucky Medical Center, Lexington

6 Neurology - Neurosurgery, Postgraduate Course, University of Kentucky Medical Center, Lexington

20 KAGP Northern Kentucky Seminar, 9:30 a.m., Holiday Inn Cincinnati South, South Fort Mitchell, Ky.

FEBRUARY

9-10 Pulmonary Physiology for Practicing Physicians. University of Kentucky Medical Center.

16 Obstetrics for General Practitioners. 9:00 a.m.—4:00 p.m., University of Kentucky Medical Center.

MARCH

24-26 Pediatrics Refresher Course, University of Kentucky Medical Center, Lexington.

IN SURROUNDING STATES

NOVEMBER

12-13 Association of Clinical Scientists, Statler Hilton Hotel, Washington, D.C.

17-20 American Academy of Orthopedic Surgeons, Postgraduate Course on Treatment of Injuries, Marriott Motor Hotel, Dallas

22 American Cancer Society and National Cancer Institute, Symposium on Hodgkins Disease, New York Hilton Hotel, New York City

28 Medical Aspects of Sports, AMA National Conference, Benjamin Franklin Hotel, Philadelphia

28-Dec. 1 AMA Winter Clinical Conference, Philadelphia

29-Dec. 2 Postgraduate Course on Pulmonary Function in Health and Disease, New Orleans, La.

DECEMBER

7-9 Southern Surgical Association, The Homestead, Hot Springs, Va.

JANUARY

12-13 Ophthalmology, Postgraduate Course, Cleveland Clinic, Cleveland, O.

19 Vascular Surgery, Postgraduate Course, Cleveland Clinic, Cleveland, O.

SEND IN MEETING INFORMATION

Many medical organizations are setting dates for their fall and winter meetings. At the same time they are choosing the topics to be discused, arranging for speakers and planning programs.

The Continuing Medical Education office of the Kentucky Medical Association would like to urge these societies and organizations to notify this office of these dates and topics so they can be added to the "Continuing Education Opportunities" calendar in The Journal. In this way conflicts in dates can be avoided and a wider audience can be informed of these upcoming meetings.

Please send such information, when available, to the KMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Kentucky 40205.

a rapid lift from the hell of depression



Doré Illustration
from
Dante's Inferno

often relieves mental pain in 2-5 days

NORPRAMIN®
(desipramine hydrochloride)

Norpramin is a rapid-acting specific drug for the treatment of depression. Depressive signs and symptoms—sometimes described as "mental pain"—typically begin to improve in 2-5 days. Patients are more hopeful, less empty and less weighed down by their troubles. Norpramin has only slight sedative qualities, nevertheless anxiety *secondary to depression* is frequently relieved as depression is lifted. If anxiety or tension persists it can be controlled by adding a tranquilizer or by reducing dosage. Norpramin is not a MAO inhibitor. Side effects are usually mild.

DOSAGE AND ADMINISTRATION

Optimal results are obtained at a dosage of about 150 mg./day—two 25 mg. tablets t.i.d. After achieving optimal results, a maintenance dose (50-100 mg./day) should be sought.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

IN BRIEF:

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

Contraindications and Precautions: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established.

Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

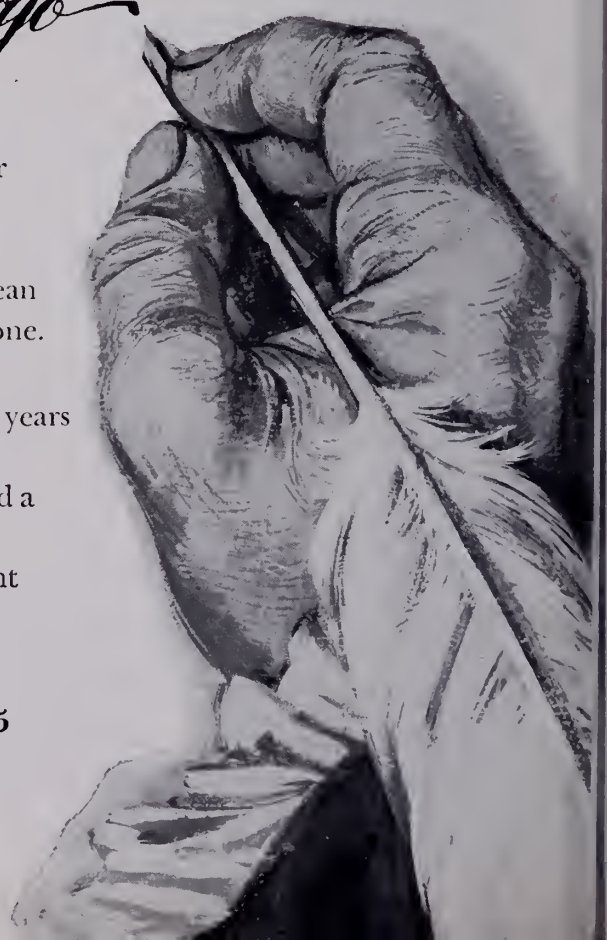
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Hypertension has been called the price of success... and in some life-situations, the cost of failure. In either event, Metatensin lowers blood pressure, cushions the patient against stress and retards the progress of disease. Metatensin is effective and economical. It is well-tolerated over long periods.

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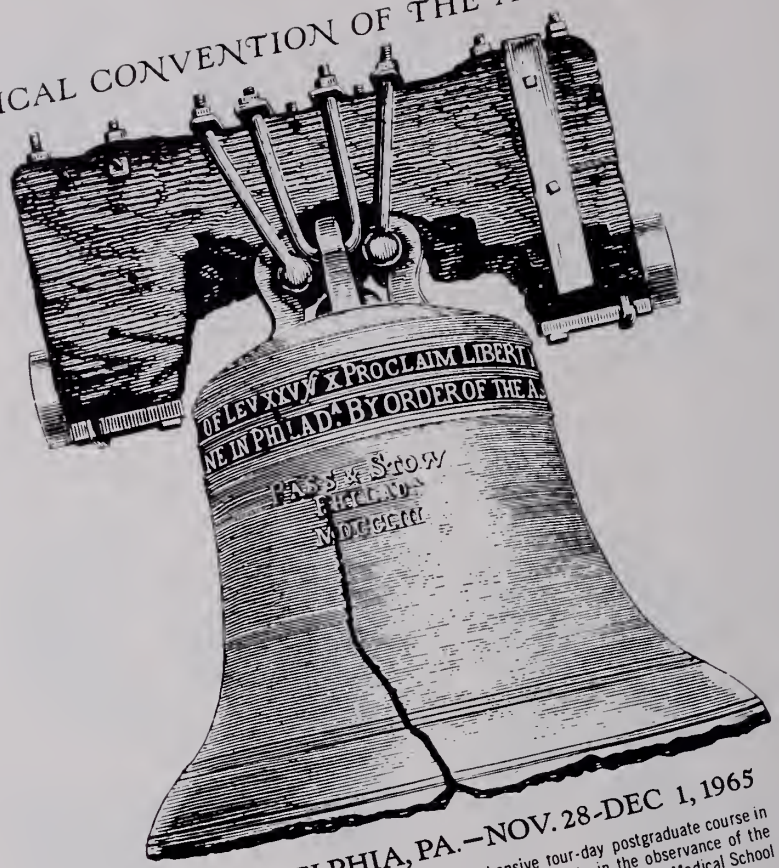
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EACH SCORED TABLET CONTAINS:
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In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.
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approximating the diuretic efficacy of meralluride

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To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.



Answers to Questions About Your Blue Shield

Q. If I intend to change my address to practice in another town in Kentucky or to move out-of-state or retire, should I notify Blue Shield?

A. *Yes. If a physician changes his address, Blue Shield should be informed by letter, in order that all correspondence including payments due for services be sent to your correct address. If you move out-of-state or retire from private practice, it is important that Blue Shield be notified also.*

Q. Can a member apply for Blue Shield Schedule C or D at any time?

A. *Direct pay members pay quarterly and can apply at any billing period. Also, an entire group may change to C or D Blue Shield at any regular re-enrollment period or a special re-enrollment may be held. Each subscriber in the group must reclassify to either Schedule C or D.*

Q. How much and what percent of Blue Shield payments in 1964 were made for various services?

A.

Surgical	*$4,999,783*	*54.41%*
Medical, Obstetrical and other services	*$4,189,250*	*45.59%*

Q. Why are many large national firms refusing to continue "indemnity" surgical-medical plans?

A. *Indemnity schedules provide allowances toward the doctor's charge for covered services. The subscriber has no predictability of how much difference he may need to pay over the allowance made. Management and labor have negotiated in many instances to furnish full payment contracts for specified benefits which offer predictability of cost for the employee and company.*

Q. Why does Blue Shield send to doctors Internal Revenue Form 3435 requesting identifying number and Internal Revenue Form 1099 statement of Blue Shield payment for past year?

A. *Blue Shield is required by law to provide the physician's identifying number to the Internal Revenue Service if Blue Shield paid him as much as $600 in the fiscal year. Likewise, Blue Shield must notify both the Internal Revenue Service and the doctor of payments made during a given tax period.*

Q. If I perform different types of services on the same patient on the same day, for instance, fracture care and x-ray, can I file them on the same Blue Shield report?

A. *Yes. However, it will be necessary that you give a separate charge for each service.*

Q. If the same procedure, for example a prothrombin test, is performed on the same patient on several different days, should I file these on one claim?

A. *No. When services are performed on different dates, a separate report should be filed for each date.*

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: **ACTIONS AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

in iron deficiency anemia for rapid and predictable replacement of iron reserves

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(iron dextran injection)



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COLIC, often in part a reflection of family tension, adds sleepless nights to patients' and parents' distraught days. Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying, improves feeding patterns . . . permits sleep and rest . . . for patient and family.

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PIPTAL® (pipenzolate bromide) efficiently suppresses acid secretion and motility . . . relieves pain and spasm of peptic ulcer. Despite its potent gastrointestinal effects, "its clinically effective therapeutic dose is well below that required to produce side reactions."[1] Because urinary retention is rarely a problem, PIPTAL (pipenzolate bromide) is "a highly desirable drug in the treatment of peptic ulcer in older patients . . ."[2] Tolerance to PIPTAL (pipenzolate bromide) has not been demonstrated, and the drug may be administered over prolonged periods without loss of efficacy. *PIPTAL-PHB is specifically designed for the tense ulcer patient who will benefit from the sedative effect of phenobarbital.*

1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957

2—Asher, L.M.: Am. J. Digestive Diseases *4*:272 (Apr.) 1959

PIPTAL®
(pipenzolate bromide)

PIPTAL®-PHB
(phenobarbital, 16 mg., pipenzolate bromide, 5 mg.)

IN BRIEF: PIPTAL—Each tablet contains 5 mg. pipenzolate bromide, PIPTAL-PHB—Each tablet (or 5 cc. of elixir) contains phenobarbital (warning: may be habit forming) 16.0 mg., Piptal (pipenzolate bromide) 5 mg. The elixir contains alcohol 20%.

Side Effects: Dry mouth, blurring of vision or drowsiness may occur.

Contraindications: Withhold in glaucoma, bladder or g.i. obstruction, cardiac arrhythmias and in sensitivity to anticholinergics or phenobarbital (Piptal-PHB). Caution should be observed in patients with prostatic hypertrophy.

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Supplied: PIPTAL (pipenzolate bromide) 5.0 mg. Tablets—bottles of 100. PIPTAL-PHB Tablets—bottles of 100. PIPTAL-PHB Elixir—bottles of 8 fluid ounces.

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Side Effects: Occasional allergic skin reactions may occur with meprobamate, accompanied by fever, nonthrombocytopenic purpura, angioneurotic edema, hypotension, or bronchial spasm. Drowsiness with or without ataxia and/or alteration in visual accommodation may occur. Effects of alcoholic beverages may be increased by meprobamate. Use with caution in patients with coronary or cardiovascular disease or severe hypertension. Prolonged use may result in dependence. Reactions can occur if drug is not withdrawn gradually.

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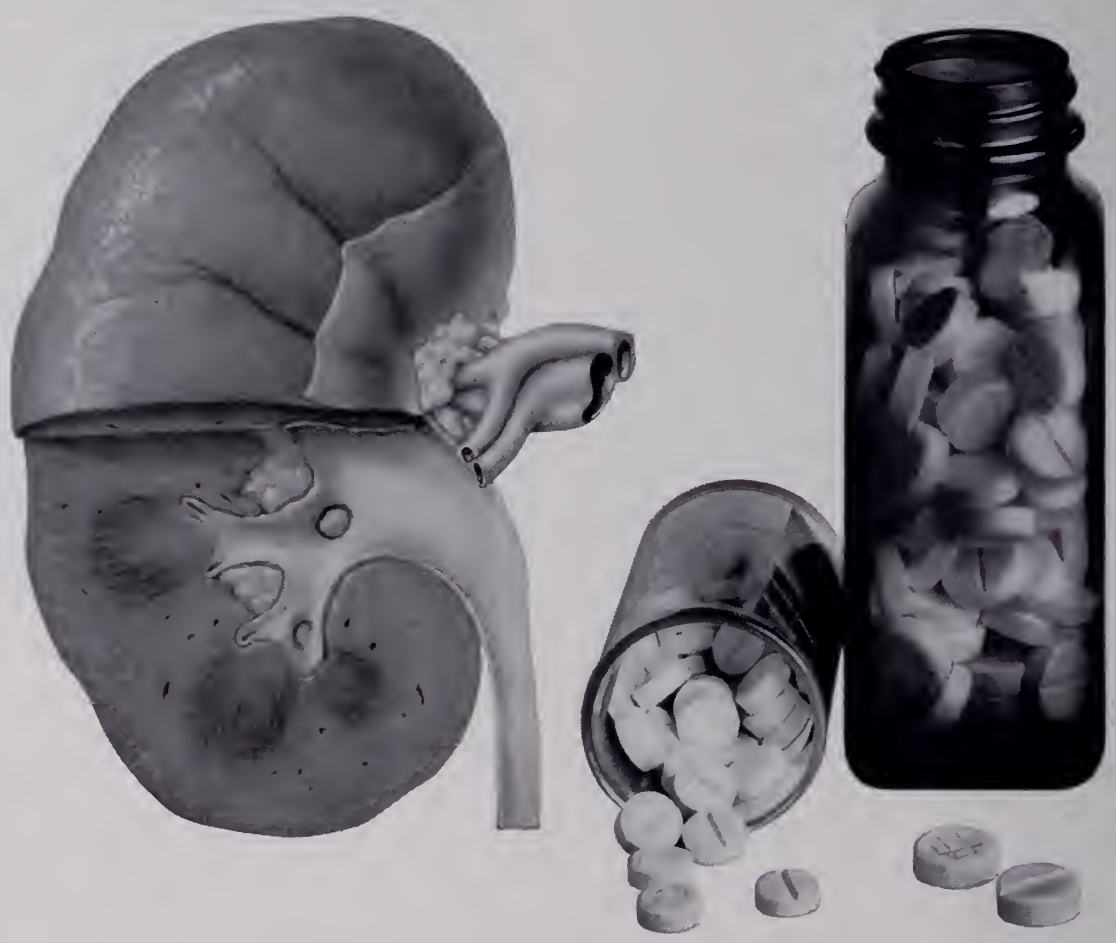
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Each tablet contains 0.75 mg. prednisone, 325 mg. acetylsalicylic acid, 20 mg. ascorbic acid, 75 mg. aluminum hydroxide.

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at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

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DBI-TD lowers blood sugar
without stimulating insulin secretion

DBI-TD lowers blood sugar
and may restore toward normal excessive insulin secreted in response to hyperglycemia

DBI-TD lowers blood sugar
without accelerating lipid synthesis and fat accumulation

in the diet-unresponsive, overweight, stable adult diabetic

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Thus DBI-TD together with proper diet usually affords effective control in the overweight, ketoacidosis-resistant diabetic... reduces high blood sugar and elevated serum insulin levels, and leads to gradual weight loss. Anorexia has been suggested as a possible basis for weight loss; however, controlled studies suggest that it is due to the mechanism of drug action. Comparable dosages of DBI-TD do not induce weight loss or lower blood sugar in nondiabetic subjects. For the ketoacidosis-prone diabetic, insulin is still the essential hypoglycemic drug.

Now in its seventh year of clinical use... DBI-TD affords simple, convenient once-a-day or at most twice-a-day dosage for most patients.

Dosage: 1 to 3 capsules daily. **Side Effects:** Gastrointestinal, occurring more often at higher dosage levels, abate promptly upon dosage reduction or temporary withdrawal. **Precautions:** Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis which is accompanied by acidosis, and treated accordingly. Lactic acidosis has been reported in nondiabetics and diabetics treated with insulin, with diet, and with DBI. Question has arisen regarding possible contribution of DBI to lactic acidosis in patients with renal impairment and azotemia and also those with severe hypotension secondary to myocardial or bowel infarction. Periodic B.U.N. determinations should be made when DBI is administered in the presence of chronic renal disease. DBI should not be used when there is significant azotemia. Any cardiovascular lesion that could result in severe or sustained hypotension, which may itself lead to development of lactic acidosis, should be considered cause for immediate discontinuation of DBI at least until normal blood pressure has been restored and is maintained without vasopressors. Should lactic acidosis occur from any cause, vigorous attempts should be made to correct circulatory collapse, tissue hypoxia, and pH. **Contraindications:** Severe hepatic disease, renal disease with uremia, cardiovascular collapse. Not recommended without insulin in acute complications of diabetes (metabolic acidosis, coma, severe infections, gangrene, surgery). **Pregnancy Warning:** *During pregnancy, until safety is proved, use of DBI like other oral hypoglycemic drugs, is to be avoided.*

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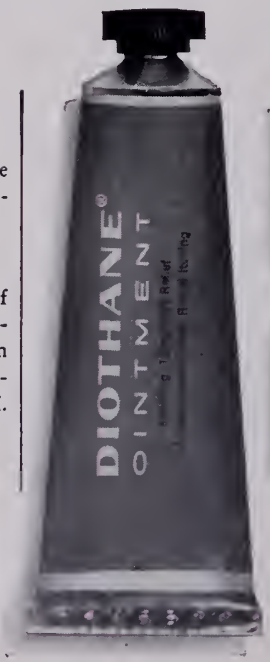
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COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

Merrell

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especially in elderly or debilitated patients

and in diabetics — patients with a history of fungal overgrowth — patients on steroids who require antibiotics. The antimonilial specificity of Nystatin plus the extra benefits of DECLOMYCIN Demethylchlortetracycline allow lower mg intake per dose per day, the option of b.i.d. dosage, higher activity levels, 1-2 days' "extra" activity.

Side Effects typical of tetracyclines include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation) and increased intracranial pressure (in young infants). Also, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. Because of reactions to artificial or natural sunlight (even from short exposure and at low dosage), patient should be warned to avoid direct exposure. Stop drug immediately at the first sign of adverse reaction. It should not be taken with high calcium drugs or food; and should not be taken less than one hour before, or two hours after meals.

Average Adult Daily Dosage: four divided doses of 1 capsule each or two divided doses of 2 capsules.

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The effectiveness of intramuscular penicillin. Just three 250-mg. doses daily provide total twenty-four-hour penicillin blood levels equal to those achieved by injection of 600,000 units of procaine penicillin G. A fourth dose increases daily penicillemia to levels 35 percent above those achieved by injection.

Consistent dependability—even in the presence of food. Comparative pharmacologic data show that V-Cillin K produces peak blood levels *twice* as high as those of penicillin G, with *half* the dose.

New, thin coating . . . new size and shape. The new coating eliminates the characteristically bitter taste of oral penicillin and makes V-Cillin K tablets easy to swallow. The new shape makes them easy for physicians and pharmacists to identify.

Indications: V-Cillin K is an antibiotic useful in the treatment of streptococcus, pneumococcus, and gonococcus infections and infections caused by sensitive strains of staphylococci.

Contraindications and Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

Supplied: Tablets V-Cillin K, 125 or 250 mg., and V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

V-Cillin K®

Potassium Phenoxymethyl Penicillin

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana.

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The JOURNAL of the
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VOLUME 63 NOVEMBER 1965 No. 11

Interposed Jejunal Segments in Ulcer Surgery†

George B. Sanders, M.D.*

Louisville, Ky.

An interposed jejunal segment to restore gastro-duodenal continuity after high gastrectomy, is safe, and physiologically effective in preventing dumping and other symptoms of post-cibal or "small stomach" distress. In previously gastrectomized patients, jejunal interposition effectively cures severe dumping, and post-cibal distress.

Introduction

MODERN surgery has many uses for interpolated jejunal segments, as, for example:

1. Replacement or bypass in esophageal cancer operations.
2. Substitute reservoir after total gastrectomy for cancer.
3. Conduits for internal drainage of pancreatic and choledochal cysts, the common bile duct, and the pancreatic stump after Whipple resection of the pancreatic head for cancer.

The employment of single jejunal segments in ulcer surgery is relatively new, and owes its introduction to English and Scandinavian surgeons.

Henley,[6] in England, probably was the first to employ the isolated jejunal segment as a conduit between the gastric stump and the duodenum, not only for correction of dumping after Billroth II procedures, but also as an initial reconstruction in a radical gastric resection in order to preserve the Billroth I type of continuity. Henley's first operation of this kind was done in 1951.[6] In 1957, he reported his experience in 115 patients.[7]

Rationale

In England and in Scandinavia, where the incidence of peptic ulcer is nearly twice that in the United States, vagotomy and an emptying procedure has not achieved the prominence that it has enjoyed in America. Over there, gastric resection remains the procedure of choice, especially for the chronic peptic ulcer of males. The physiological superiority of the Billroth I reconstruction is recognized, but it is felt that ulcer recurrence following this procedure is too high and is due to stasis in the gastric pouch, and to the removal of too little stomach. If more stomach is resected, mortality rises due to leakage at the gastro-duodenal suture line from too much tension. Dumping, rare in the conservative Billroth I resection, becomes common in the higher resections, approximating the frequency of dumping seen after Billroth II resections.

An isoperistaltic jejunal segment interposed between stomach and duodenum has been found markedly successful in reducing leakage, mortality, and dumping. Hedenstedt,[1, 4] in Sweden, reports 347 cases in which primary or secondary jejunal transposition was done. The distribution of the series, complications,

† *Presented at the annual Norton Memorial Infirmary Seminar in Louisville on December 17, 1964.*

* *Clinical professor of surgery, University of Louisville School of Medicine, Louisville, Ky.*

and mortality are shown in Tables 1, 2, and 3.

TABLE 1. DISTRIBUTION OF THE SERIES*

Ulcer 273 Cases (Primary Jejunal Transplant)	
Gastric Ulcer	80 Cases
Duodenal Ulcer	193 Cases
Dumping Syndrome 57 Cases (Secondary Jejunal Transplant)	
After Billroth I	13 Cases
After Billroth II	43 Cases
After Total Gastrectomy	1 Case
Carcinoma of the Stomach 17 Cases (Primary Jejunal Transplant)	
Total Cases	347 Cases

* Adapted from Hedenstedt,[3] with the permission of the author.

TABLE 2. EARLY POSTOPERATIVE COMPLICATIONS*

Complications Due to the Special Nature of the Operations:	Primary Jejunal Transplant	Secondary Jejunal Transplant
a. Haemorrhage	–	1
b. Gastric Retention	2	–
c. Intestinal Obstruction	1	1
d. Peritonitis	–	1
e. Pancreatic Complications	1	2
f. Hepatic Complications	1	–
g. Intestinal Complications	1	1
General Postoperative Complications:		
h. Shock	1	1
i. Pulmonary Complications	5	2
j. Thrombo-embolism	3	–
k. Wound Rupture	3	–

*Adapted from Hedenstedt.[3]

TABLE 3. MORTALITY RATES*

Primary Jejunal Transplant, all cases	290 Cases
Deaths	6
Mortality	2.2%
Primary Jejunal Transplant Elective Cases	265 Cases
Deaths	2
Mortality	0.75%

* Adapted from Hedenstedt.[3]

It is important to reflect as Hedenstedt points out, that, if eight desperate cases of life-threatening bleeding, for which emergency operation and primary jejunal transposition was done, are excluded, the mortality of the procedure in 265 elective ulcer operations falls to 1.75%.[1, 4] Hedenstedt believes that, using primary jejunal interposition, a safe and satisfactory high resection can *always* be accomplished, preserving the physiological advantages of a Billroth I restoration of continuity, and avoiding dumping.[1, 2, 3, 4]

In those cases where gastrectomy has been followed by severe dumping, a secondarily interposed jejunal loop has consistently been followed by dramatic relief of symptoms, and by correction of weight loss and anemia. Hedenstedt claims also that fecal fat and nitrogen losses, though they continue to be abnormal, are much reduced after jejunal interposition.[1, 4, 5]

The only unfavorable complication reported is a serious one: late peptic ulceration in the implant. In Hedenstedt's series this occurred in 3.7%, but in Henley's experience,[17] 23% of the gastrectomies with jejunal transposition for duodenal ulcer in men developed this complication.[7, 8] Both Henley and Hedenstedt agree that this occurs only in the duodenal ulcer cases, and mainly in males, and that it can be prevented or cured by vagotomy.[5, 8] Hedenstedt states that no vagotomized case has as yet developed this complication. He also maintains that vagotomy has been found necessary to protect the implant only in duodenal ulcers, or in juxta-pyloric ulcers with high acid; never in gastric ulcer.[1, 4, 5]

American surgeons have, so far, failed to corroborate in the laboratory the claims of Scandinavian surgeons that jejunal interposition corrects fecal nitrogen and fat losses.[18, 19] In the United States, where high gastrectomy for ulcer has been discredited, main dependence for definitive ulcer surgery has been placed on vagotomy coupled with an emptying procedure, or with antrectomy, and therefore the need for an interposed jejunal prosthesis does not often arise.

Dumping, however, continues to be an important problem, even after conservative resections. The few American investigators who have pursued this subject into the field of clinical investigation, agree that dumping symptoms and weight loss are dramatically relieved by jejunal interposition.[10, 11, 14, 16, 17] Recently, a few investigators have been employing reversed jejunal segments in the interposition operation and in other situations with interesting results.

Technic

The technic of jejunal interposition is simple. After appropriate gastric resection, a segment of proximal jejunum not far from the ligament of Treitz is chosen, and a portion about 15 cm. long is isolated and divided between intestinal clamps. Jejunal continuity is restored by end-to-end anastomosis ventrocaudally to the isolated segment, which is then brought up through a small opening in the

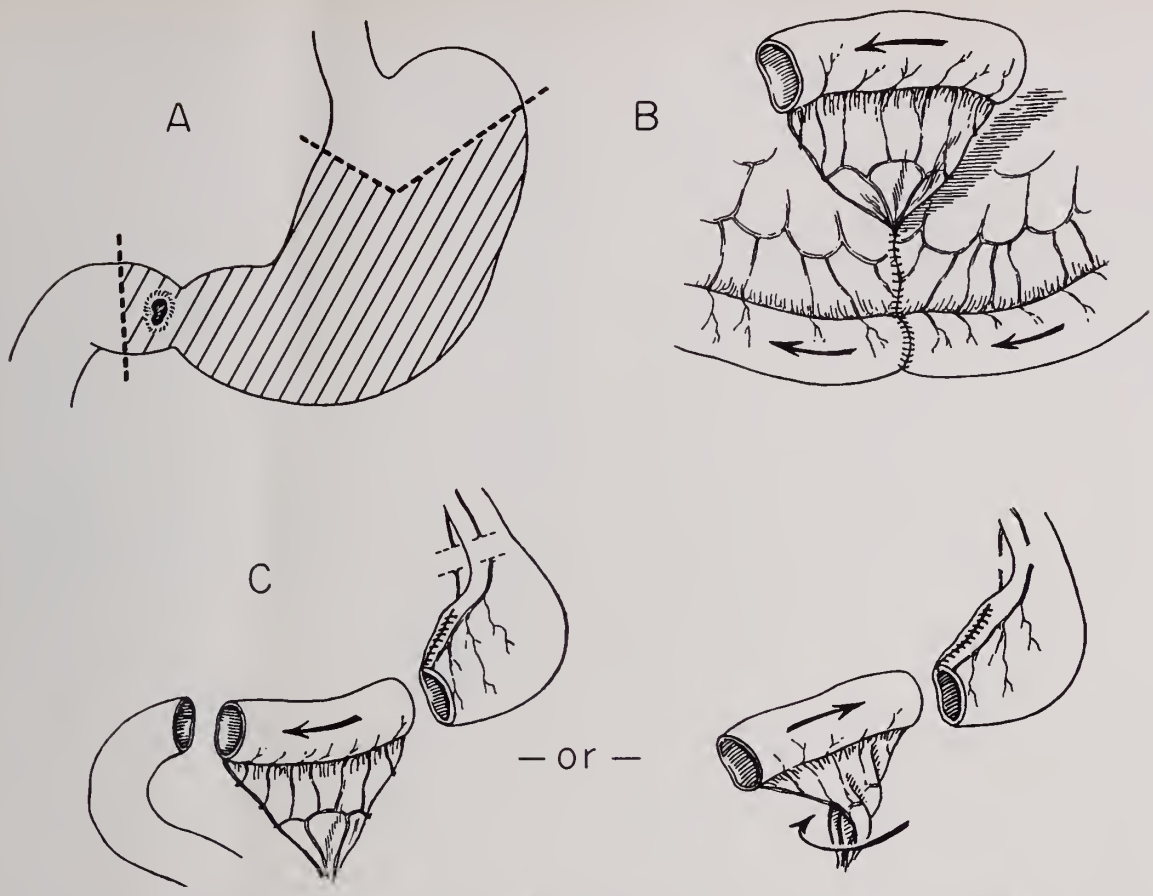


FIGURE I. Technic of Primary Jejunal Interposition. A. Limits of resection. (shaded area). B. Isolating the jejunal segment. Arrows indicate direction of peristalsis. C. Fitting the interposed segment. Vagotomy ALWAYS necessary with isoperistaltic interposition, usually necessary with antiperistaltic or reversed interposition.

gastric mesocolon to be interposed between the duodenum and the gastric stump. Nonabsorbable sutures are used throughout. (Figure I)

Hedenstedt believes he has demonstrated a sphincter-like effect of the interposed jejunum on the passage of gastric content from the gastric stump toward the duodenum. He believes that this forms the basis for its corrective effect on dumping. The English and Scandinavian surgeons use an isoperistaltic segment of jejunum exclusively. A few American surgeons, notably Herrington[10,11] and others, have employed antiperistaltic jejunal segments in a few cases with gratifying results.[15, 18, 19]

Case I

V. T., a 47-year-old white male with a 15-year history of intractable ulcer, had undergone four prior inadequate ulcer operations elsewhere. (Figure II, 1-6) Three months after the last operation, which was apparently an attempt at subtotal gastric resection, vagotomy, and a Billroth I reconstruction, his ulcer symptoms returned with greater severity than before. He was grossly underweight and almost cadaverous. The Hollander test indicated intact vagi, and a very high acid level, suggestive of Zollinger-Ellison syndrome. X-ray examination of the stomach showed gross deformity and changes suggestive of gastric ulceration. At operation it was found that the patient had a giant perforating ulcer of the anterior gastric wall, eroding into the anterior abdominal wall. (Figure II, 7) The entire pylorus and most of the antrum were still present, despite two previous distal resections. After two prior attempts at subdiaphragmatic vagectomy, the status of his vagus nerve trunks was obscure, and access to the esophageal hiatus was completely obliterated by dense adhesions.

It was decided:

(1) To resect the pylorus and antrum completely along with the giant ulcer, and, to do this, a very high, near-total, gastrectomy was found necessary.

(2) To do a Billroth I type reconstruction in order to restore gastro-intestinal con-

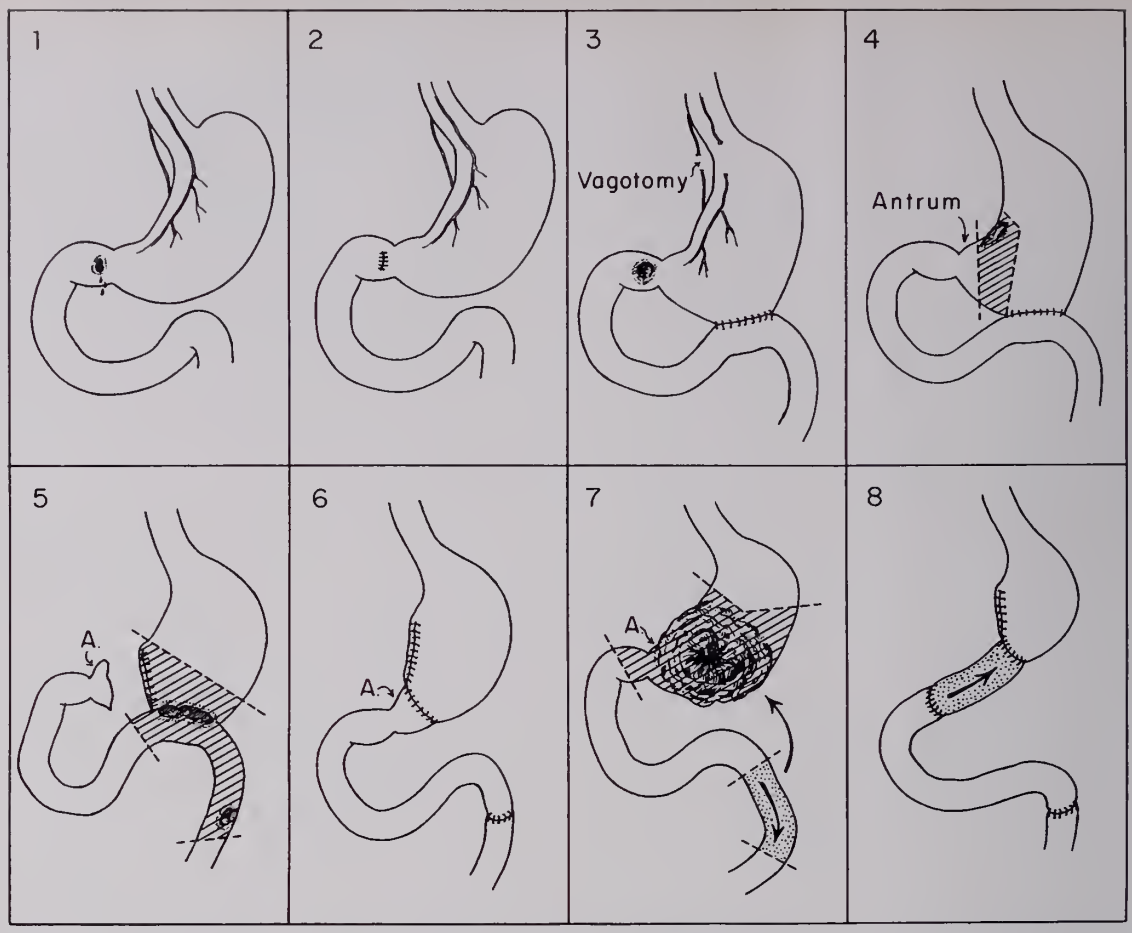


FIGURE II. Surgical Odyssey of patient, V.T. (Case I). Arrows indicate peristaltic direction. Antral remnant indicated by A.

tinuity by the most physiologic means possible.

(3) To interpose a jejunal segment to bridge the large gap between the tiny gastric pouch and the duodenum.

(4) To reverse the interposed jejunal segment to prevent the severe dumping which almost certainly would follow the resection of so much stomach, and also to protect further against recurrent ulceration, since the completeness of vagal interruption was unknown.

This procedure was carried out with remarkable ease, and a most satisfactory reconstruction, surgically and anatomically, was obtained. (Figure II, 7,8)

Postoperatively, the patient did extremely well, and his convalescence was very smooth. He was able to resume oral feedings within three or four days after surgery, progressed well without any manifestations of gastric retention or dumping, and has, in the subsequent 12 months of his postoperative career, maintained his weight easily, been entirely free of pain, and has exhibited no manifestations of dumping. He eats an entirely normal diet, qualitatively and quantitatively, with satisfaction and pleasure. (Figure III)

Case II

K. M., a 38-year-old white female patient had a vagotomy and hemigastrectomy for duodenal ulcer five years previously, a Billroth I reconstruction being done. From the first, she had moderate dumping symptoms which became very severe after a cholecystectomy two years ago. She had lost approximately 25 pounds in weight, and was unable to maintain or gain weight. She had severe nausea, vomiting, and diarrhea after eating. All manner of medical routines, treatment, and drugs, including serotonin antagonists, had been employed without avail. There had been no evidence of recurrence of ulcer, or of ulcer symptoms. Examination revealed an underweight white female who appeared chronically ill. Her abdomen was semi-scaphoid, with a well



FIGURE III. X-ray film of patient V.T. (Case I) one month after operation. Arrow indicates gastric pouch. X indicates jejunal implant.

healed left rectus scar. There were no abnormal masses or tenderness. A Hollander insulin test showed complete vagal interruption. Because the patient was unable to retain any form of carbohydrate test meal for the purposes of determining a glucose tolerance curve, the rapid intravenous administration of glucose was done, with a resulting normal curve ruling out the possibility of pancreatic dysfunction, and/or diabetes. The remainder of her physical examination and laboratory studies were uncontributory.

At operation, a well-healed and normally appearing Billroth I gastrectomy was disclosed. There was no evidence of inadvertent retention of any part of the antrum or pylorus. The gastroduodenal anastomosis was taken down by means of a limited resection of the previous suture line. A jejunal implant measuring 12 cm. in length, was brought up and interposed in reversed position (Figure I,C) between the gastric pouch and the duodenum. A single layer of inverting interrupted mattress sutures of fine cotton sufficed for the anastomoses between implant, stomach, and duodenum. The operation was easily carried out.

The postoperative course was entirely uneventful. As soon as a relatively normal diet was permitted postoperatively, it was at once apparent that the very prominent manifestations of dumping, nausea, vomiting and diarrhea had been completely relieved. To date, five months after surgery, she still has no dumping, but has not been able to gain weight, although she maintains her preoperative weight without difficulty. She is now able to eat a normal diet including many foods, such as milk, which she was formerly unable to tolerate.

Case III

D. S., a 50-year-old white female had had a 75% partial gastrectomy with a Billroth II reconstruction four years before, for intractable duodenal ulcer. Vagotomy had not been done. Beginning one month after operation, symptoms of severe dumping developed and continued unabated despite extensive medical and dietary regimens. She lost 35 pounds in weight, became weak, and unable to do her housework. X-ray examination showed a very small gastric remnant, prompt emptying, and rapid intestinal passage. Ulcer symptoms had not recurred, and gastric analysis showed hypoacidity.

At operation, no evidence of ulceration, either stomal, jejunal or recurrent duodenal was found. The efferent jejunal loop was divided flush with its application to the lesser gastric curvature, and the gastric end was turned in. The efferent loop was divided just distal to Treitz's ligament, and the loop, measuring 12 cm. long, still attached to the gastric pouch, was swung up and anastomosed to the reopened duodenal stump, end to end, converting the efferent loop to an anti-peristaltic interposed jejunal segment between gastric pouch and duodenum. (Figure IV, a and b) The distal efferent loop was then joined to the sectioned proximal stump of the afferent loop, end to end, at the ligament of Treitz, reconstructing duodeno-jedjunal continuity. (Figure IV, b). Except for the employment of an antiperistaltic jejunal segment between stomach and duodenum, this procedure was identical with Henley's remedial operation for the correction of dumping, (first done by F. C. Henley in 1951) which is the prototype of all subsequent interposition operations.

Postoperatively, the patient did well, and when last seen two months after operation, had no symptoms of dumping or of post-cibal distress, ate a normal diet, and was gaining weight (10 pounds).

Discussion

English and Scandinavian surgeons have been obtaining highly satisfactory results, using an isoperistaltic 15 cm. jejunal loop in-

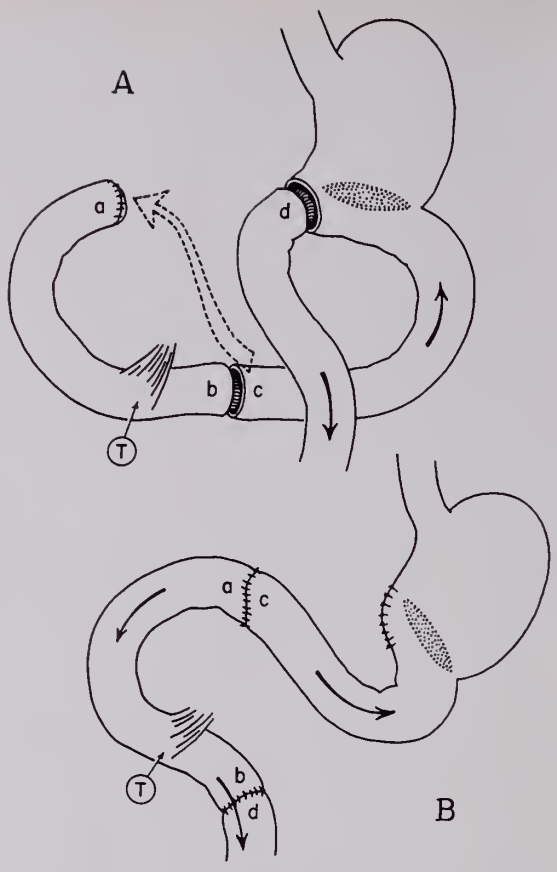


FIGURE IV, a and b. "Henley's Remedial Operation". Peristaltic direction indicated by solid black arrows. Ligament of Treitz indicate by (T).

terposed between gastric pouch and duodenum, in high Billroth I gastrectomies for ulcer. There is universal agreement that vagotomy must be done to protect against ulceration of the isoperistaltic implant, unless near total or total gastrectomy is done at the same time.[1,4,5,] Ulceration inevitably occurs in this segment of jejunum, which remains immune when employed in the gastrojejunostomy of a 75% Billroth II gastrectomy, and the reason is thought to be that the isoperistaltic direction of the interposed jejunal loop encourages gastric acid to flow over the jejunal mucosa unprotected by alkaline duodenal reflux. Actually, alkaline reflux is inhibited by the peristaltic direction of the jejunal segment.[1,4] It is thought that in the reversed jejunal segment, duodenal reflux is favored by the reversal of peristalsis in the segment, and ulceration is therefore less likely. In such reversed segments, a vagotomized gastric pouch might fail to empty against peristalsis, and it might be safer on both counts to omit vagotomy if a reversed segment is used. Herrington,[10] who has done five such procedures as secondary operations for the dumping syndrome, feels that vagotomy is necessary unless a very high resection has been done, and finds no trouble with emptying in the face of vagotomy provided short (6 to 8 cm.) reversed segments are used. Poth advises against vagotomy with his more complicated jejunal pouch, for fear of obstruction or stasis. Herrington observed ulceration in one case with a nonvagotomized Poth pouch, and apparent healing after transthoracic vagotomy. The same investigator has not observed obstruction in previously vagotomized patients in whom he has subsequently inserted Poth pouches.[10,11] As stated previously in this paper, Hedenstedt[5] has yet to observe a stomal or jejunal ulcer in an isoperistaltic jejunal implant in a vagotomized patient, but feels that vagotomy is unnecessary when dealing with gastric ulcer. To date, Hedenstedt excels in the magnitude of his material and the excellence of his results. He now reports a total experience of 600 cases using the isoperistaltic jejunal loop, with a mortality of less than 1%.[5]

Summary

(1) The use of a jejunal segment to restore continuity in a physiologic manner after a high gastric resection, is a valuable adjunct to ulcer surgery.

(2) To guard against ulceration in the implant, vagotomy should be done at the time, unless an exceedingly high gastrectomy is done.

(3) In previously vagotomized patients it is well to check on the integrity of vagal interruption by the Hollander insulin test, before resorting to jejunal interposition.

(4) If indications are that vagi are intact or partly intact, a very high resection must be done and the jejunal segment should be reversed, to protect against dumping and ulceration, unless a complementary vagotomy can be done.

(5) In cases of dumping, bilious vomiting, or post-cibal distress, after gastric surgery, for either ulcer or cancer, jejunal interposition is an effective remedy.

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(Continued on Page 915)

Neurosurgical Implications of Metastatic Carcinoma†

Charles B. Wilson, M.D.*, and Horace A. Norrell, Jr., M.D.**

Palliation of symptoms due to incurable cancer constitutes a major part of the practice of medicine. Certain complications of advanced cancer fall within the province of neurosurgery and this report is based upon their recognition and management.

Pain

Pain commonly arises during the course of malignant tumors. Surgical interruption of the pain pathways should be considered when a patient does not obtain relief from codeine or other non-addicting drugs. Addiction to narcotics rapidly produces psychic and physical deterioration with a loss of the desire to live which greatly increases the victim's demands on the family and physician. A pain-relieving operation may be advised for severe pain in any patient expected to survive for three months or longer.

Cordotomy—interruption of the lateral spinothalamic tract—is the most commonly employed procedure for pain relief. In use for over 50 years, it is probably the best of the several operations for relief of pain.[13] A satisfactory result can be predicted in 85% of the cases and the hospital mortality should be below 5%.

Cordotomy is performed in either the high thoracic or high cervical spinal cord.[5, 13] The high cervical operation produces superior results in our hands and is applicable to pain anywhere below the neck. The procedure may be extended to include the cervical area by combining cordotomy with cervical posterior root section.

The operation is often performed for pain originating from carcinoma involving structures in the pelvis. Pelvic and lower extremity pain, frequently bilateral, may be relieved by bilateral section in either one or two stages using local or general anesthesia. Temporary urinary retention, a frequent complication of bilateral cordotomy, is readily accepted by the patient successfully relieved of chronic pain.

Rhizotomy—division of the posterior spinal roots—produces total anesthesia as opposed to loss of only pain and temperature with cordotomy. Posterior rhizotomy is particularly useful for pain in the neck and occiput within the distribution of the cervical plexus, but cordotomy is preferred for pain in most other areas. Rhizotomy is not applicable to the extremities except in rare instances because an anesthetic extremity is useless.

Intracranial section of the fifth and ninth cranial nerves is an excellent procedure for the relief of pain from locally invasive tumors of the face, mouth, and throat. This operation is usually combined with section of the upper four cervical roots to control accompanying neck pain. The combined procedure is surprisingly well tolerated and its effectiveness justifies more frequent application.

Classical frontal lobotomy can no longer be recommended in the treatment of pain. Selective destruction of frontal white matter can be accomplished without producing the distressing personality changes which regularly accompany complete frontal lobotomy. The procedure is employed when pain cannot be controlled by one of the foregoing operations or when severe narcotic addiction and psychiatric factors contraindicate a direct approach to the pain pathways.

Spinal Cord Compression

Involvement of the spinal cord by metastatic tumor to the extradural space is a frequent complication in the patient with cancer. The

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attitude of pessimism which prevailed a decade ago must be replaced with one of therapeutic aggressiveness if permanent paraplegia is to be averted. The condition must be treated as a neurosurgical emergency in order to achieve favorable results. Useful recovery is rare if the lesion has caused complete interruption of cord function prior to operation. The keynote is early recognition and prompt decompression.

The natural history of extradural spinal tumors can be divided into two stages, the stage of prodromal symptoms and the stage of spinal cord symptoms. Pain is the outstanding and often the only prodromal symptom. The pain is of two types, local pain in the spine and root pain. Radiographic evidence of vertebral involvement is usually present at this early stage. The patient with metastatic carcinoma complaining of back pain should have frequent neurological examinations to detect signs of early spinal cord compression.

Whereas the prodromal stage of local pain may extend over a period of weeks or months, the stage of spinal cord compression is usually brief, weakness progressing to paraplegia in a matter of hours or days. The first indication of spinal cord compression is weakness closely followed by sensory symptoms and later by sphincter involvement. Symptoms may appear abruptly when collapse of a destroyed vertebral body results in acute compression of the spinal cord.

Myelography is indicated as an emergency procedure in the face of impending paraplegia. Immediate laminectomy is mandatory when a complete spinal block is demonstrated. A trial of radiation therapy is permissable only when the block is incomplete, signs of cord compression are mild, and the tumor is known to be highly radiosensitive, conditions rarely satisfied with tumors other than lymphomas. The objective of surgery is decompression of the spinal cord by an adequate laminectomy and removal of the underlying tumor.[3]

The relief of pain, the prevention of decubiti, the restoration of sphincter control and partial return of motor function are worthwhile benefits of surgery and help to lighten the nursing burden and make the patient's remaining life more comfortable.[14] Given a patient with incomplete motor and sensory paraplegia the chances of a good result are a little higher than 50%.[3] The ultimate results are best when spinal cord compression has developed slowly. In the final analysis the results of decompressive laminectomy are directly related to the neurologic status of the patient at the time of operation.

Intracranial Metastasis

Neurosurgeons of twenty years ago did not knowingly operate upon metastatic brain tumors although a small number of primary extracranial tumors were unsuspected and craniotomy was undertaken with the mistaken diagnosis of a primary brain tumor. This attitude has changed as a result of several factors:

1. Improved methods for combating cerebral edema have lessened the risk of surgery in the patient with a cerebral metastasis.
2. Refinements in diagnostic techniques have led to more accurate localization of small metastatic tumors associated with massive cerebral edema.
3. The life expectancy of patients with disseminated cancer has been prolonged by the use of hormones and cytotoxic agents so that prognosis following removal of a metastatic brain tumor has improved.
4. Finally, impressive results have been obtained with added experience in the careful selection of patients for neurosurgical intervention.

Intracranial metastases develop in 16.5% of patients with extracranial neoplasms, the highest rates being associated with lung (42%), breast (25%), and melanoma (51%).[1] Metastatic tumors currently make up 10% of all brain tumors removed in active neurosurgical centers[3] with lung and breast as the most common primary sites.[9]

The biologic behavior of a tumor can be judged by the speed with which it disseminates to distant sites. The interval between primary operation and the appearance of a cerebral metastasis is 6-12 months in 75% of lung tumors, beyond 2 years in 70% of breast tumors and beyond 3 years in 62.5% of renal tumors.[9] Many tumors of the lung are first discovered during the course of neurologic investigation and one-sixth will not be detected on chest films at this time.[8] The majority of metastatic brain tumors have reached a diameter of 2 cm. by the time neurologic signs appear but exceptions to this rule are common because of the variable degree of associated cerebral

edema.[10, 12] Edema of an entire hemisphere may be caused by a single small metastatic tumor and fluctuations in clinical manifestations can be explained on this basis. No reliable figure can be given for the incidence of solitary metastatic brain tumors but the majority of metastatic lesions attacked by the neurosurgeon are solitary.[9]

Headache is the earliest and most frequent symptom, being the chief complaint in one-third and a secondary symptom in another one-third of patients. Other frequent symptoms are hemiparesis, personality changes and convulsions.[6, 9] The majority of patients have increased intracranial pressure at the time of admission which accounts for the high frequency of headaches.

Final selection of patients for craniotomy involves a number of judgements. The main factor determining post-operative survival is the general physical condition of the patient. Debilitated patients and those whose life expectancy is limited due to extracranial complications are excluded from consideration. The manifestations of intracranial involvement which justify a major operation are increased intracranial pressure, disabling neurologic deficit and severe headaches unrelieved by analgesics.[4] Excision of the primary tumor is not essential for long survival following removal of a brain metastasis but a long interval between removal of the primary tumor and the appearance of an intracranial metastasis is a favorable feature, particularly if there are no other sites of metastatic involvement. Surgery is rarely worthwhile in the presence of multiple intracranial tumors and the demonstration of more than one tumor by angiography, air studies, EEG, or isotope brain scan narrows the field to those with an apparently solitary metastasis. Finally, removal of the tumor should not leave the patient with severe neurologic impairment.

The poorest results occur in patients with pulmonary tumors, either primary or metastatic. Excluding those with a positive chest film, 50% will survive for 6 months or longer following excision of an intracranial metastasis. Long-term survivals have been reported even in patients whose primary tumor was not removed.[2, 6] Resolution of cerebral edema surrounding the tumor is a primary factor leading to the improvement which follows removal of a small metastatic tumor.

Chemotherapy can be employed in selected instances as an adjunct to surgery or as a definitive measure. In an earlier study reported by one of us,[15] 50% of metastatic tumors responded favorably. The agent is administered by continuous carotid infusion and the rate of complications has been low.

In conclusion, surgical excision of an apparently single intracranial metastasis is worthwhile if the patient is in good general physical condition. The favorable results achieved in many cases justify a more optimistic attitude regarding cerebral metastases.

Carcinoma of the Breast

The management of patients with disseminated carcinoma of the breast is a complex problem which concerns the neurosurgeon only indirectly. Approximately one out of every three breast tumors is hormone dependent and almost 50% of hormone dependent breast tumors will enter into another period of remission following either adrenalectomy or hypophysectomy.[11]

The results following adrenalectomy and hypophysectomy are identical and the surgical complications have been comparable. However, the recent development of stereotactic cryohypophysectomy, a safe and simple method for total ablation of the pituitary gland, will change the frequency with which hypophysectomy is employed. Developed by Rand[7] at the University of California the method involves destruction of the gland by a freezing probe directed into the pituitary fossa through the sphenoid sinus. The probe is positioned by a sterotactic device using local anesthesia. This technique avoids the distressing complications of cerebrospinal rhinorrhea, meningitis and cranial nerve palsies which have been encountered with other trans-sphenoidal methods. The availability of cryohypophysectomy will broaden the indications for a major endocrine ablation in the palliation of advanced breast cancer.

Summary

Four manifestations of disseminated cancer concern the neurosurgeon. Pain can often be relieved by an appropriate interruption of the pain pathways. Spinal cord compression must be recognized at an early stage and relieved

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Current Management of Extracardiac Arterial Lesions

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The diagnosis of extracardiac arterial lesions is related to suspicion. Arteriograms may be recommended in selected cases. Reconstructive arterial surgery is usually the most appropriate solution to arterial lesions.

Several allied factors have catapulted direct arterial surgery into its orbit of current acceptability. Safer arteriograms, amassed experience of the operator, refinement in surgical procedures, and sound postoperative regimens have combined to improve salvage rates. Also, retroperitoneal exposures have reduced postsurgical bowel ischemia and respiratory complications. Still to be solved is the problem of the ideal, universal arterial replacement.

Generally, limb ischemia is characterized by absence of pulses, paleness, lowered skin temperatures, collapsed superficial veins, absence of swelling, and limited exercise performance. By contrast, extremity venous occlusion is distinguished by swelling, cyanosis, and local increase in temperature. The incidence of correct diagnosis is roughly dependent upon suspicion. Arteriosclerosis is the most common causative agent. The prime objective in management should be the reestablishment of as near normal blood flow as possible.

Extracranial Cerebro-Vascular Disease

Thirty to forty per cent of significant obstructions are extracranial. Recurrent little strokes suggest extracranial occlusions. Usually, those blocks develop at the junction of the vessels with the aorta or at the "Y" of the common carotid artery. Presently, intracranial disease is inoperable. Symptoms of intermittent carotid occlusion include transient paralysis and paresthesias of the extremities and face, blindness, and motor aphasia. Auscultation frequently uncovers a bruit at the carotid bifurcation. Hints of vertebral insufficiency are tinnitus, dizziness, and unsteady gait as well as blackouts. Differential blood pressures in the upper extremities coupled with central nervous system symptoms suggest vertebral occlusion. Arteriograms are essential for the diagnosis.

Careful patient selection is important. Reconstructive procedures are probably futile if the carotid bifurcation is totally obstructed. Patients with progressive strokes of more than two to four hours duration usually do not benefit from the removal of the thrombosis. If the symptoms of stenotic extracranial disease are present, if the arteriogram localizes the lesion to the cervico thoracic area and if aggravating medical problems are not present, surgery should be advised[4].

Usually, partial occlusion of the main carotid division is amenable to endarterectomy. Kink-



FIGURE 1. Carotid bifurcation stenoses are usually managed by endarterectomy. Generally by-pass grafts are elected for arch lesions.

ing of the internal carotid artery is comparable to bifurcation stenosis. It may be managed by excision and replantation. By-pass grafts may be used to advantage with lesions at the source of the carotid arteries. Vertebral artery occlusive disease lends itself well to endarterectomy.

Renal Hypertension

Generally, hypertension due to renal artery obliteration is diagnosed by exclusion. The history, supported by a urinalysis and urine cultures, may indicate either pyelonephritis or glomerulonephritis. Deranged serum electrolytes, that is, a low potassium and elevated carbon dioxide point to an aldosterone tumor. Increased catecholamines or vanillyl mandelic acid tests shift suspicion toward a pheochromocytoma. All remaining young hypertensives, patients with abrupt changes in blood pressure, and uncontrolled hypertensives deserve arteriograms. A flat film of the abdomen may demonstrate a small kidney. Often an intravenous pyelogram is more dense on the affected side. Kidney scanning will not differentiate ischemia due to parenchymal disease from ischemia induced by renal artery stenosis. Only arteriograms will clarify the problem.

The decision to recommend renal artery surgery must be made with certain reservations. Postoperatively, kidney function may be improved but the hypertension may endure. The blood pressure may remain unchanged if the unoperated kidney has been altered by arteriolar disease. Also, the blood pressure may decline only to rise again. However, the hypertension may be more easily controlled by medication after arterial surgery. Bilateral renal biopsies are helpful in predicting the consequences.[10]

If the splenic artery is free from arteriosclerosis, a splenorenal graft may by-pass a left renal artery stenosis. On the right, an endarterectomy or by-pass graft from the aorta or iliacs may be utilized. It is probably adventuresome to tackle both kidneys at the same sitting or to remove a kidney without unquestionable indications.

Acute Mesenteric Artery Occlusion

Either an embolus or arteriosclerotic plaque is responsible for this condition. Most often, the origin of an embolus is a fibrillating heart. Commonly an embolus lodges at the middle colic branch, inciting intense surrounding spasm. The facies of the patient often prompts the diagnosis. He is hyper-alert, moaning, and unable to achieve relief by position or opiates. He complains of agonizing abdominal cramps which may produce flatus or bloody stool. Usually an elevation of temperature and rapid respiratory rate herald the onset of gangrene. Generally, in arteriosclerotic obstruction, aortic bifurcation disease or femoral artery occlusion can be detected. By contrast, the course of proximal superior mesenteric thrombosis may be insidious and deceptive. About one-third of the patients with thrombosis have a history of chronic mesenteric ischemia prior to complete occlusion.

Since there is an approximate ninety-four percent mortality in acute occlusions, early exploration seems mandatory. Transabdominal exposure of the superior mesenteric artery is usually sufficient for embolectomy. Retrograde clot is a dismal finding but the results have improved with the Fogarty embolectomy catheters.[6] If an unsuspected arteriosclerotic obstruction is discovered, a by-pass from the aorta, common iliac, or splenic artery may be employed. However, the splenic artery may be unacceptable since the coeliac axis is usually obliterated before intestinal ischemia develops.

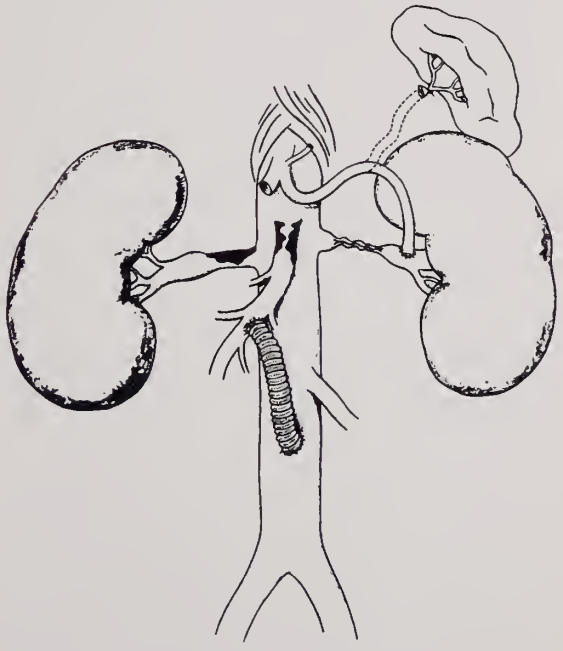


FIGURE 2. Splenorenal by-pass may be employed when renal artery stenosis or fibromuscular hyperplasia involves the left renal artery. An aorto-superior mesenteric artery graft may be utilized to restore blood flow to the intestine when proximal obliterative disease is present.

Little reluctance should be exhibited in reexploring the patient for persistance of restlessness and prostration implies progression of mesenteric ischemia.[8]

Chronic Mesenteric Insufficiency

Customarily, there is impressive weight loss from this disease. Eating, especially meat, induces intestinal cramps. A bruit may be heard near the umbilicus. Stools are frequently bulky and foul smelling, suggesting malabsorption. Peripheral arterial occlusive disease is usually noted. Lateral or oblique aortograms are required to confirm the diagnosis. A stenosis of the superior mesenteric artery may be relieved by endarterectomy. Retroperitoneal exposure of the proximal superior mesenteric artery makes endarterectomy technically easier. Otherwise, a by-pass graft from the aorta is elected.[8]

Acute Upper and Lower Extremity Occlusions

Approximately ninety percent of these occlusions stem from embolism. The diagnosis of peripheral arterial embolism is made by detecting a source for the embolus and the absence of pulses distal to the point of lodgment. Frequently, the patient complains of extreme pain, paralysis, numbness, and coldness peripheral to the occlusion. With obstruction of the popliteal artery, the demarcating line is roughly at the low calf or ankle level. When the obstruction is at the bifurcation of the femoral artery, the dividing mark seems near the junction of the lower and middle thirds of the thigh. When the common iliac or aortic bifurcation is occluded, the boundary travels to the upper third of the thigh. Similar areas of demarcation may be associated with entrapment of an embolus in the brachial, axillary, or subclavian arteries. Clot forming distal to the embolus may intensify symptoms. Usually, arteriograms are not necessary.

Unless there are definite inhibiting reasons, the most logical approach to embolism is surgical removal. Conservative therapy may salvage the member yet leave it unreasonably disabled.[1] The Fogarty embolectomy catheters have reduced saddle aortic embolism to a femoral procedure. About ten percent of acute peripheral obstructions may be charged to atheromata. Evacuation of retrograde clot as well as elimination of the primary obstruction is essential for restoration of blood flow.

Chronic Aorto-Iliac Occlusion

Almost all chronic aorta-iliac occlusions are attributed to arteriosclerosis. Claudication of the thigh and buttocks defines the obstruction. Absent femoral pulses are a prime diagnostic clue. Generally, there is no peripheral wasting. Even though skin temperatures are lower, there is little dependent rubor. Aortograms are imperative.

Unless remarkable calcification accompanies a limited aorto-iliac thrombosis, an endarterectomy appears to be the operation of choice.[3] Diffuse arterial disease probably justifies an aorto-femoral by-pass. Limited lumbar sympathectomies may be done concomittantly to enhance the outflow tract.

Chronic Femoro-Popliteal Occlusive Disease

Generally, in this condition, the atherosclerotic occlusions are located at the popliteal bifurcation, in the adductor canal, or at the mouth of the superficial femoral artery. Claudication of the ankle and calf are distinguishing



FIGURE 3. Limited aorto-iliac thrombosis can be corrected by endarterectomy. For long obstructions in the femoro-popliteal artery, a vein graft seems to provide better long term results.

features. Skeletonization of the leg and foot is a reflection of diffuse obliterative disease. Poor venous filling is a grave prognostic sign. Gangrene of the toes may occur. When rest pain is prominent, multiple sites of occlusion are likely. Small vessel disease is more common in diabetics. Arteriograms are requisite to determine location, extent, and run off.

Only patients with reasonable run off arteries should be subjected to reconstructive surgery. In the lower extremities, the long blocks should be managed with by-pass grafts using a reversed saphenous vein.[7] Short occlusions may be handled by endarterectomy and patch vein graft. If there is additional arteriolar disease in the foot, a lumbar sympathectomy appears justified.

Aneurysms

Almost ninety per cent of abdominal aortic aneurysms victimize the distal aorta below the renal arteries. Usually, the non-ruptured variety presents as a pulsatile mass in the neighborhood of the umbilicus. Symptoms may be vague but frequently embrace indigestion, back pain, sciatica, or rarely, claudication from emboli or twisting of the iliacs as the aneurysm expands. Usually, aortograms are unnecessary. Frequently, the limits of the aneurysm can be outlined by lateral x-ray films of the lumbosacral spine.

The ruptured aneurysm presents a different problem. The outlook is grave. The elective resection rate of ten percent jumps to thirty to fifty percent. Persistent bleeding, declamping cardiac arrest, renal shutdown, bowel infarction, and sepsis all contribute to a higher mortality. Shock, severe back pain, and a large, pulsating abdominal mass quickly brings a ruptured aneurysm into focus. If the blowout has been into the peritoneal cavity, death is imminent. Frequently, the veretebral bodies or psoas muscle will tamponade the leak until resuscitative measures can be instituted.[9]

The natural history of an aneurysm is rupture. Unless some outstanding reason can be found for not doing so, an aneurysm should be resected and replaced with a plastic graft.[5] Declamping shock has been reduced by adequate blood replacement, gradual release of the proximal clamp, preclotting of the prosthesis, and vasopressors. Apparently, renal failure has been diminished by Mannitol infusions. Also, bowel ischemia may be minimized by serial epidural block and circulation through at least one hypogastric artery. Retroperitoneal exposure carries less morbidity if the operator is dealing with a sharply defined aortic aneurysm.

Aneurysms in other peripheral vessels demand equal attention.

Summary

Current problems relating to peripheral arterial lesions have been enumerated. Usually, embolism is most appropriately handled by surgical removal. In the management of occlusive disease, endarterectomy appears most applicable to short occlusions. By-pass methods seem better adapted to lengthy obstructions. The trend is toward the substitution of autogenous material for vessel replacement. By-pass vein graft remains the procedure of choice for long blocks in the lower extremities. Since the course of aneursysms is eventual rupture, elective resection is highly recommended. Presently, Dacron or Teflon prostheses are the only suitable replacements following resection of an abdominal aortic aneurysm.

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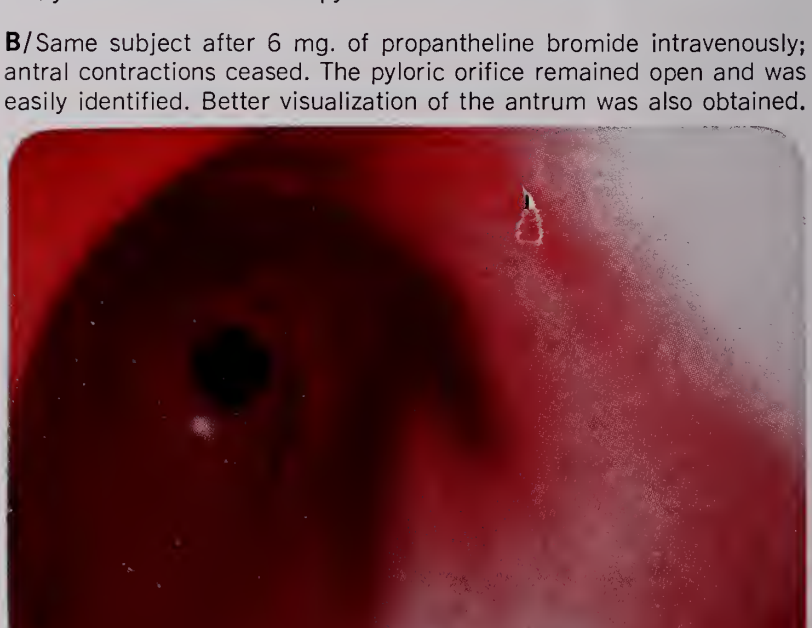
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Intragastric photography studies[1]



A/ E. B., male, age 48. Normal antral contraction. Pyloric opening is not seen. It is difficult to differentiate a deep prepyloric contraction from a "pyloric fleurette" or true pylorus.

B/Same subject after 6 mg. of propantheline bromide intravenously; antral contractions ceased. The pyloric orifice remained open and was easily identified. Better visualization of the antrum was also obtained.



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(propantheline bromide)

Pro-Banthine is so effective in anticholinergic action that it may be employed in visualizing the entire pyloric region.

In addition to the intragastric photographs, cinegastroscopic studies[2] have demonstrated graphically not only its effectiveness but the superiority of Pro-Banthine over belladonna alkaloids.

Pro-Banthine produced complete cessation of gastric, antral and pyloric motor activity with a dose of 6 mg. intravenously. This is approximately one-third the usual oral dose of 15 mg.

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It is this pharmacologic superiority of Pro-Banthine which has made it the most widely prescribed anticholinergic in such conditions as peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

Dosage—The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15 mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily.

Side Effects and Contraindications—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

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SEARLE

Research in the Service of Medicine

Percutaneous Splenoportography†

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Technique, hazards, and indications for this procedure are outlined and illustrated. Its safety and value have been documented. Every patient considered for portacaval shunt surgery should be so studied.

RADIOGRAPHIC visualization of the portal venous system was first reported by Blakemore in 1945.[1] The procedure consisted of the injection of radiopaque media into a tributary of the portal venous system at laparotomy in order to select the proper surgical venovenous shunt procedure. Since this method prolonged surgery and required the surgeon to make his incision without knowing what procedure was to be performed, techniques were sought which could provide this information pre-operatively. Splenoportography (i.e., radiographic visualization of the portal venous system by intrasplenic injection of contrast material) was first reported by Pereira in 1951.[2] The injection however was still performed at laparotomy and therefore did not correct the major disadvantage of the procedure. The percutaneous approach to intra-splenic portal venography was first practiced in experimental animals by Abeatici and Campi[3] in 1951. Very shortly following this, Leger[4] and Boulvin et al[5] described percutaneous splenoportography in humans. During the next five years several reports, predominantly from Europe, attested to the value of this procedure.[6,7,8,9] A most notable contribution was by Atkinson and Sherlock[10] in 1954. They demonstrated that intra-splenic pressure measurements afforded an accurate appraisal of the portal vein pressure. It therefore became possible with single non-operative procedure to not only detect and quantitate portal hypertension but to determine its effect on the portal venous system. In the middle of the 1950's several papers dealing with this procedure from American authors began appearing.[11,12,13,14,15,16,17]

Other means of visualizing the portal venous system have been attempted. Percutaneous injection of intra-hepatic branches of the portal vein has been performed by Steinbach et al[18,19] without serious complications. In addition, Rigler[20] has demonstrated portal venous system visualization by taking a delayed abdominal aortogram. Neither of these methods however allows extra-hepatic portal visualization and both are somewhat more hazardous. A supplemental procedure was first described by Rappaport[21] in 1951. This consists of wedging a double balloon catheter in the inferior vena cava with the lumen between the balloons and opposite the hepatic vein. Retrograde hepatic venograms may then be made following Hypaque injection. This procedure combined with hepatic vein wedge pressures allows the partial evaluation of patients whose spleen has been removed and who therefore cannot undergo splenoportography.

Technique

The procedure is usually performed in the x-ray department unless major uncorrectable bleeding tendencies exist. In this event it may be done immediately pre-operatively in the operating room, however here only a single film will be available for evaluation. When performed in x-ray a rapid film changer for serial x-rays (each half second for 12 seconds) is utilized. The patient assumes a supine position on the x-ray table with the left forearm under his head. Seventy five milligrams of meperidine hydrochloride (Demerol) intravenously and local anesthetic infiltration is given immediately prior to the procedure. Depending upon the size and location of the spleen, the site for the needle insertion is the eighth or ninth intercostal space from the midaxillary to the posterior-axillary line. With the patient holding his breath in expiration, a number 18 spinal needle is inserted

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into the spleen. Slight resistance can be detected on entering the splenic tissue and the flow of venous blood from the needle on withdrawal of the stylette indicates proper location. Once proper location is obtained, shallow breathing is resumed and splenic pressure is measured with a saline filled spinal fluid manometer connected to the needle by a flexible polyethylene tube. The tube permits measurements to be made while the patient is breathing. Values above 200 millimeters of saline are abnormal. Following pressure measurements, the manometer is replaced by a syringe containing 25 milliliters of 50 per cent sodium diatrizoate (Hypaque). This material is injected as rapidly as possible during which time films are made every half second for twelve seconds. The needle is then immediately withdrawn. A delayed film ten minutes later will give one an excretory urogram as the dye is excreted by the kidneys. Bed rest is maintained for twenty four hours and vital signs are measured frequently for the first six hours.

Results and Hazards

Our results have been reported elsewhere[16,17] and agree with those of larger series.[14,15] Suffice it to say that successful roentgen visualization of the portal venous system varies from 85 per cent to 90 per cent as does successful and accurate appraisal of portal vein pressure. Causes for failure are generally (1) improper needle placement, (2) splenic subcapsular collection of contrast material or (3) technical failure of the x-ray equipment.

The complication rate has been surprisingly low when adequate precautions are taken. Not infrequently evidence of intraperitoneal hemorrhage has been noted at laparotomy performed shortly following such procedures. Blood loss of a degree to require transfusion has occurred in only 2 per cent of five hundred cases reviewed by Figley.[22] Persistent hemorrhage requiring splenectomy has been reported, but rarely. As with any procedure involving intravenous injection of iodine containing contrast material, hypersensitivity reactions, although rare, must be kept in mind and emergency treatment must be available should they occur.

Indications for Portal Splenoportography

1. Determination and Quantitation of Portal Hypertension. Even though most patients with portal hypertension show evidence of this by other findings, such as esophageal varices, splenomegaly or other collateral venous patterns, this is by no means always the case. In addition a patient may present evidence of portal cirrhosis by liver biopsy and esophageal varices by esophagoscopy and still have a relatively normal portal vein pressure. It therefore becomes important to determine the portal vein pressure when shunt surgery is anticipated since patients in this latter catagory would not benefit substantially by such surgery. By serially observing patients with cirrhosis, Sherlock's group found certain patients with portal hypertension but without significant collateral circulation and therefore in no immediate danger of bleeding from esophageal varices. With the establishment of significant collateral venous circulation the pressure in the portal venous system may return to normal. The patient has, for the moment, alleviated by natural means the elevated venous pressure but now is in danger of bleeding from these dilated veins in the esophagogastric plexus. In these two circumstances only splenoportography can determine whether or not surgical treatment is indicated. The following case illustrates this.

Case I. This 46 year old alcoholic was hospitalized in 1954 following grand mal seizures and discovered to have liver disease. He was again hospitalized in 1957 because of a flare up of chronic discoid lupus erythematosis and at this time gave a history of anorexia, weight loss, continued heavy alcohol intake and recurrent fever. Physical evaluation revealed scleral icterus, a liver descending 5 centimeters below the right costal margin and erythematous scaling lesions over the ears and face. Laboratory studies revealed a hemoglobin of 9.8 bm %, a hematocrit of 30 mg %, total serum bilirubin 4.5 mg %, cephalin-cholesterol flocculation 3 plus, bromsulphalein retention of 50% in 45 minutes, serum albumin 2.5 gm % and globulin 3.6 gm %. Stools were positive for occult blood. Esophagoscopy demonstrated esophageal varices and a liver biopsy showed evidence of Laennec's cirrhosis. Because of the anemia, evidence of bleeding and esophageal varices, portacaval shunt surgery was considered. A percutaneous splenoportogram was



FIGURE 1, Case 1: Splenoportogram showing normal-sized splenic and portal veins, with some "streamlining" due to inflow of blood from the superior mesenteric vein. Coronary and short gastric veins are well shown, and esophageal varices are demonstrated.



FIGURE 2, Case 2: A dilated, very tortuous splenic vein is seen, but the portal vein is thrombosed and is not visualized. Subcapsular extravasation of contrast material outlines the lower pole of the spleen.

performed however and revealed a splenic pulp pressure of only 220 millimeters of saline. This was repeated one month later and the pressure was only 170 millimeters of saline. Figure 1 shows a relatively normal sized splenic vein but evidence of collateral venous circulation through the short gastric and coronary vessels. Because of these findings, shunt surgery was not done and the patient gradually improved and returned to duty.

Comment

Without splenoportography the patient would have been exposed to the relatively high mortality-morbidity of portacaval surgery operation was thus avoided.

2. Preoperative Selection of the Best Shunt Operation. In our experience, portacaval shunt procedures are preferred to those involving the splenic and renal vessels and are less apt to thrombose post-operatively. A portacaval shunt cannot be performed if the portal vein is thrombosed or has undergone cavernous transformation. The surgical approach to a portacaval anastomosis is through a right thoraco-abdominal incision; the approach to a lienorenal shunt is through a left abdominal incision. It therefore behooves the surgeon to know in advance which procedure he is to perform.

Case 2. This 38 year old white male was hospitalized in 1956 for unexplained melena. He had a history of gout and recurrent renal calculi but not of hepatitis, exposure to hepatotoxins, alcholism or dietary deficiency. Physical examination revealed hepatosplenomegaly in a rather obese individual. Laboratory studies demonstrated mild leukopenia, thrombocytopenia and anemia. Bromsulfalein retention was 30% in 45 minutes and liver biopsy showed evidence of post-necrotic cirrhosis. At esophagoscopy large varices were seen.

Portacaval shunt surgery was planned, however because of an anesthesia reaction, was cancelled. The patient returned to duty but entered the hospital one year later with recurrent melena. At this time a splenoportogram was performed (Figure 2). The splenic pulp pressure was 350 millimeters of saline and the splenoportogram revealed a tortuous dilated splenic vein with occlusion of the portal vein at its beginning. Since portacaval shunt surgery was not feasible a splenorenal shunt was performed with excellent relief of portal hypertension and disappearance of esophageal varices.

Comment

Even though an intra-hepatic cause for portal hypertension was evident by liver biopsy, an associated extra-hepatic portal vein thrombosis made portacaval surgery impossible. This vividly demonstrates that one cannot depend upon indirect evidence in determining the site of occlusion of the portal venous system. The mortality and morbidity from shunt surgery is high enough without the additional risk of prolonged operating time, multiple incisions and increased blood loss of a double operation.

3. Postoperative Evaluation of Surgical Shunt Efficiency. Patients who have had porto-systemic vein shunt surgery are subject to conditions which may well be confused with thrombosis or obstruction of the surgical shunt. The incidence of peptic ulcer disease is considerably increased and upper gastro-intestinal bleeding may be erroneously ascribed to esophageal varices. Hepatic failure with encephalopathy is a frequent cause of death but the so-called "meat" or "protein intoxication" is a milder and readily treatable form of hepatic coma. In the event of thrombosis of a portacaval shunt with recurrent portal hypertension and bleeding esophageal varices, a splenorenal shunt may be performed with excellent results. Splenoportography therefore is often of considerable value in demonstrating the cause for a sudden downhill course in a post-shunt cirrhotic patient with gastro-intestinal bleeding.



FIGURE 3, Case 3: Patent portacaval shunt in a patient with esophageal varices and gastrointestinal bleeding 18 months after portacaval shunt operation.

Case III. This 46 year old white male alcoholic had hepatomegaly for seven years before admission. Massive hematemesis in 1955 prompted admission. Esophagoscopy showed esophageal varices and Laennec's cirrhosis was present on liver biopsy. Another massive hematemesis in 1956 led to a portacaval shunt, following which the varices disappeared. One year later, because of tarry stools, weight loss and icterus the patient was re-admitted. Physical examination revealed marked pallor, a sinus tachycardia, a hemic murmur, a liver enlarged to four finger breadths below the right costal margin, many spider angiomata, palmar erythema and pedal edema. Significant laboratory findings included a hemoglobin of 4 gm %, total serum bilirubin of 2.8 gm %, bromsulfalein retention of 22% in 45 minutes, serum albumin 2.1 gm %, alkaline phosphotase of 7.6 Bodansky units and prothrombin time of 65%. Repeat liver biopsy showed no change. An upper G I series was normal. Esophagoscopy showed minimally enlarged varices with no evidence of bleeding. There was no evidence of hemolysis. A splenoportogram (Figure 3) showed a well functioning end-to-end portacaval shunt. No additional surgical therapy was therefore indicated. The patient continued to consume excessive alcohol and died.

Comment

The findings of relatively normal splenic pulp pressure and a patent portacaval shunt ruled out a surgically remediable condition.

4. Miscellaneous Indications. Sherlock's group employs bedside splenic pulp pressure as an emergency procedure in the evaluation of patients with massive gastro-intestinal hemorrhage. Since this is an indirect determination of the source of hemorrhage we prefer esophagoscopy, gastroscopy and emergency gastro-intestinal x-rays. The demonstration of portal hypertension or esophageal varices does not imply that this is the source of hemorrhage. Even in patients with cirrhosis the frequency of gastro-intestinal hemorrhage from peptic ulcer disease is greater than that from esophageal varices.

Gilsanz[23] has demonstrated what he considers a typical splenoportogram of constrictive pericarditis in that the obstruction to portal flow appears to be at the liver capsule. Combining this with a spleen-lung ether circulation time he describes a useful method of diagnosis and post-operative follow-up of patients with this condition.

Various anomalies of the portal venous tree which may or may not be symptomatic, may or may not have significant superficial collateral venous enlargement and may or may not be associated with splenomegaly, can well be demonstrated by splenoportography. Intra-hepatic tumors may be demonstrated by filling defects or increased vascularity of the intra-hepatic portal venous system. The determination of splenic pulp pressure is extremely useful in differentiating various causes of splenomegaly.

Summary

The technique, indications and results of percutaneous splenoportography have been briefly reviewed. Its relative safety makes it a useful tool in the evaluation of the portal venous system. It should always be performed if portal-systemic vein shunt surgery is anticipated for relief of portal hypertension. Illustrated case reports have been included.

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CASE DISCUSSIONS
From The
University of Kentucky Hospitals

University Hospital

Primary Thyroid and Adrenal Cortical Failure
A Hazard of Diagnostic Procedure

J. Hunter Black, M.D.,* and William W. Winternitz, M.D.**
Lexington, Ky.

Purpose

IT IS THE purpose of this report to call attention to the simultaneous occurrence of primary disease of more than one endocrine gland and the importance of recognizing this fact when performing diagnostic tests.

Case Report

P. P., a 35-year-old mother of five, was admitted to the University of Kentucky Medical Center on 2/22/64 complaining of nausea and vomiting of three weeks' duration.

In 1959, eight months after her last child, at age 30, her menstrual periods became scanty and irregular occurring at three to four months intervals and lasting only two to three days. In 1961 she became aware of decreased appetite, weakness and marked fatigue. In 1962 she was hospitalized following a syncopal episode and at that time complained of drowsiness and weakness. She was found to be anemic and was transfused with two units of whole blood. In April, 1963 she was hospitalized twice with anorexia, vomiting, weakness, low blood pressure, and anemia. During this five-year illness she had noted gradual weight loss, tinnitus, cold intolerance, increasing weakness and generalized increase in pigmentation. Her pregnancies had all been normal and were not complicated by hemorrhage or shock. The patient's mother died at age 41 of carcinoma of the cervix. She herself was treated for cervical ulceration in 1962 at age 33. There was no family history of thyroid disease.

Physical examination on admission revealed a small, slender woman who appeared lethargic and chronically ill. BP 110/85, P 54. Face and neck showed scattered brownish pigmentation, the skin was dry, rough, and flaking; the hair was dry, coarse, and thinned. Mentation was slowed but clear, the thyroid was not enlarged and the breasts were small and considered to have little glandular tissue in them. The cervix showed erosion and had a greenish discharge. The remainder of the examination was within normal limits.

Initial laboratory work revealed a Hct. of 34, Hgb. 10.8, WBC 3100, FBS 70 mg%, BUN 9 mg%, Na 122 mEq/L, K 4.2 mEq/L, CO_2 22 mEq/L, (a second electrolytes drawn the day of admission showed Na 134 mEq/L and Cl 96 mEq/L, Cholesterol 170 mg%, serum proteins of 8.4 mg% and PBI of 2.3%. Urinalysis, VDRL and stool guaiac were normal. The initial thyroid uptake of radioactive iodide (TURI) was 9.5% in 24 hours and x-ray of skull showed normal sella turcica. Control 24 hour urines were collected for steroids and Metopirone® (Mepyrapone) was given 750 mg q4h for six doses. During the evening of this study the patient complained of nausea, headache, abdominal and chest pain, and became quite apprehensive. During the early morning hours she had two grand mal seizures. She became progressively obtunded and lapsed into coma in the next few hours. At this time serum Na was 122 mEq/L, Cl 72 mEq/1 and serum osmolarity 243 m0sm/L (norm, 280-310) the clinical picture was consistant with adrenal crisis. She was then treated vigorously with intravenous hydrocortisone, saline and glucose with prompt recovery.

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Further diagnostic tests were carried out with the patient on dexamethasone and no further difficulty was encountered. The patient was given 40 units q.d. intravenous ACTH, which failed to provoke any rise in urinary ketogenic steroids and three days of TSH, 5 units q.d., failed to alter the TURI. Thyroid antibodies in a dilution of 1:250 were found using a tanned red cell method. Measureable adrenal antibodies were found by Doctor R. M. Blizzard.[1] The patient was then started on thyroid replacement. She has been maintained on two grains of dessiccated thyroid and 37.5 mg cortisone daily since discharge. A Papanicolaou smear was positive for carcinoma of the cervix (in situ) and hysterectomy has since been performed without difficulty.

Comment

In 1926 M. B. Schmidt[2] reported two cases of non-tuberculous Addison's disease with chronic lymphocytic thyroiditis. The combination of idiopathic adrenal and thyroid insufficiency has since been referred to as Schmidt's syndrome. Carpenter et al[3] recently reviewed this syndrome and presented 15 new cases, 10 of whom also had diabetes. Thirteen of these patients were found to have thyroid antibodies and nine had demonstrable adrenal antibodies. They proposed that Schmidt's syndrome is a polyendocrinopathy and perhaps an autoimmune disorder.

Schmidt's syndrome has no set pattern of endocrine failure. Thyroid and adrenal failure may occur several years apart or may occur simultaneously as in the patient presented. Her clinical picture was predominantly that of hypothyroidism and diagnostic efforts were directed at establishing pituitary function and primary thyroid failure. The Metopirone test was therefore used. By interfering with cortisol synthesis (see Fig. 1) in the already compromised adrenals, adrenal crisis was produced. Possibly some of the toxic symptoms observed in this patient were due to a direct effect of Metopirone. Had Schmidt's syndrome been clearly in mind at the time of her admission the Metopirone study probably would have been omitted and the ensuing complications avoided.

Summary

The history of a 35 year old woman with Schmidt's syndrome is presented in whom adrenal and thyroid failure occurred simultaneously. Antibodies to both the thyroid and adrenals were identified. Note is made of a hazard which may be encountered in the diagnostic work-up of such a patient.

(Continued on Page 912)

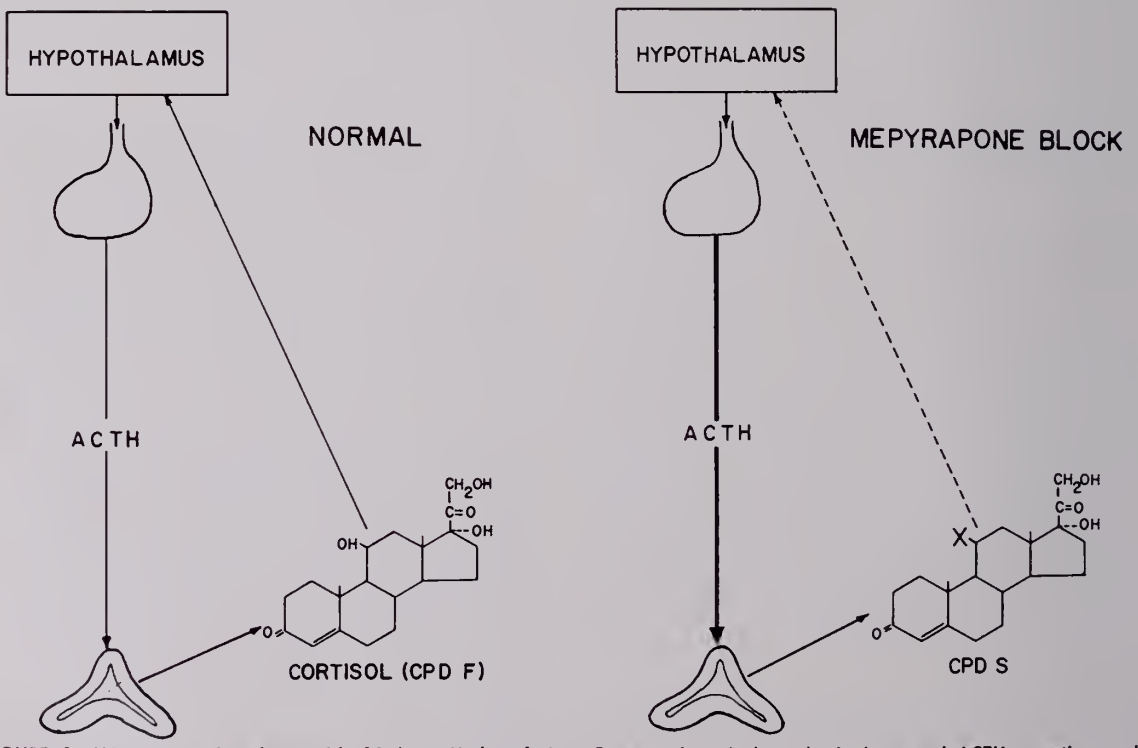


FIGURE 1. Mepyrapone interferes with 11 beta Hydroxylation. Decreased cortisol results in increased ACTH secretion and increased compound S. Normal=2 x resting urinary 17 KGS or 17 OH.

SPECIAL ARTICLES

The Great Society of Mediocrity †

DELMAS M. CLARDY, M.D.*
Hopkinsville, Ky.

A FEW YEARS ago, one of my predecessors told me privately that speaking to the senior class of the University of Louisville Medical School was one of the most satisfying experiences in his long career as a physician. I am thinking that I am about to experience the same pleasure.

Many changes have taken place at this excellent school since I occupied one of the seats in this amphitheatre thirty-three years ago. Many doctors, perhaps 3,000, have passed this way in that time; many excellent, some superior, many good and some mediocre and a few disgraceful.

I cannot go further without paying respect to the many teachers, instructors, professors and others that have given so freely of their time and efforts to make this the fine school that it is. I certainly must pay respect to a former dean, the friend of the student and an unexcelled teacher, the great John Walker Moore. Also to the man for whom this amphitheatre was named, Fred W. Rankin, truly a little giant. With him, anything less than the best was not good enough. He would certainly approve of the condemnation of mediocrity, which I am about to do. Before I do so, however, there should also be bouquets for the living; you have with you another little giant, Dean Don Smith. He likewise will not tolerate anything less than the best, which includes your present faculty. These people are carrying out the traditions of always up-grading the curriculum and standards of medical education, as it has always been in the 128-year history of the medical school. I must also give praise to Doctor Murray Kinsman, who held things together and made progress through a very difficult period.

You are to be congratulated in your choice of the University of Louisville Medical School, and for attaining your academic accomplishments.

As your first Senior Day speaker, I have been given the privilege of selecting my own subject, and perhaps a dangerous freedom of saying what I please. You are a captive audience, using one of your academic hours to hear what I have to say. I trust it will not be boring. If it is, you may gain some satisfaction in knowing that after you graduate, there will be no more lectures under the auspicies of the University of Louisville School of Medicine which you have to attend, and you, from then on, will be responsible for your own source of boredom.

The subject which I have selected is not original in its content, but it is of great concern to all of us. If you choose to reflect upon it properly, it may prove to be a source of personal initiative. The title "The Great Society of Mediocrity" is particularly appropriate at this time.

Let us start at the beginning, with anatomy, just as you started with the first thing in your freshman year. Anatomy of the brain—that remarkable organ that fills to capacity the cranial cavity. It is semi-solid and is composed mostly of water, millions of cells and complex nerve pathways and reflex relays that defy scientific understanding. The brain is arranged in lobes, their gyri and sculci with their various areas, nucleii and centers. With the assistance of the special senses it is calculated that three billion impulses per second are generated and intergrated into the nervous system during the waking state. The brain works, rests or loafs according to the dictates of that indefinable something called the will of its owner. We can willfully go or stop; steal or murder. We can work or loaf, all according to the deliberate dictates of the will. It requires almost as much activity within the brain to daydream, as it does to perform hard factual reasoning. Therefore such activity, whenever possible, should be delegated to useful purposes instead of fruitless dissipation. Incidentally, man is endowed with a brain superior to any other animal, the difference being that he has unlimited possibilities of learning and the privilege of directing his mental activity to useful purposes. He is also endowed with the will to direct that activity. If he does not choose to direct the will properly, he could find himself no better off than the lower animals. Few people develop their brains to more than a very small percentage of the total possibility. As simple examples—the blind learn to read, the deaf mute to speak and to read lips and sign language. All

† Presented to the 1965 Senior Class of the University of Louisville School of Medicine March 13, 1965, at the Kentucky Medical Association Senior Day Program at the school.

** 1964-1965 President of the Kentucky Medical Association.*

through different processes than the usual and the ordinary. Indeed the brain has great and undeveloped possibilities.

The process of learning and storing knowledge, to be recalled and stored away again is a mystery and a miracle. It is said that something once learned is never forgotten, and there is no limit to the knowledge one might accumulate. It all depends upon a healthy brain and the will of its owner. From a pool of basic facts that we learn and store away, we are able to accept the logical and reject the improbable, thus arriving at a rational conclusion, or solving a problem. This is reasoning, or abstract thinking. Combine a healthy brain and a virile will and you have a first class combination. An unhealthy brain can produce nothing but a defective individual, and not much can be expected from him. A good brain with little or no will produces a physiological disgrace, torpor, slothfulness, a bum and mediocrity. The diagnosis of this condition could be called "infirmity of the will", a shamful, insidious disease for which no wonder drug has been discovered. It is diagnosed only when our conscience tells us we are so afflicted. It can be cured only by a determined will and vigorous initiative. Should complacency set in as a complication, "infirmity of the will" becomes fatal. Remember, the brain that is capable of learning and storing facts which drives us to creativeness is also capable of driving us into daydreaming, inactivity and forgetfulness. Whichever it does depends upon the will. The brain of a moron is no different from that of a genius at the autopsy table, or by microscopical section. The size, weight, form and structure remain the same no matter how intellectual one becomes.

The human brain has always been directed toward automation, even before the wheel took precedence over the ground slide. This is the first example of human ingenuity I can think of at the present. A late example is the electronic computer. Everything that has been developed by the human brain has tended to relieve man of drudgery, both mental and physical. This is all good, but it is dangerous if it robs one of active, creative, intellectual effort. We are all creatures of comfort, and are inclined to figure out short cuts both mental and physical. For instance, who will choose to add a long column of figures when an adding machine is handy, or push a lawn mower when you can ride one? All this is an advantage and fine if the time and energy saved is used for creative activity, but the danger is that it may be an invitation to mental apathy and intellectual sterility. The one defense against these situations is a strong will and a continued performance of creative thinking in order to improve the individual competence.

We are all concerned about creeping socialism and creeping communism, but creeping lassitude is the one thing that breeds and nurtures both. Somewhere along the line during my lifetime, the philosophy of "get something for nothing" has become prevalent. It seems that a handout is more desirable than some good, honest work, and the trend is to work a little and loaf a lot. Some call it the "good life". I call it the foundation for the "Great Society of Mediocrity." At the present time the maximum work week is five days of minimal routine of labor for six or eight hours, with morning and afternoon coffee breaks and long lunch hours. To be certain that the "rights" are not infringed upon, they reserve the privilege to strike for more work with more pay. It is always less work and more pay and the law upholds such action. A year or so ago, the electrical workers in New York struck for a 25-hour week. One of the great labor leaders said a few years ago that the prime objective of his union was to bring about a situation in which ones employment would require very little of his time, and that it would only be his hobby. Now this is a real ambition—to convert vocation into avocation. What do you suppose happens to all the spare time that is accumulated? Do you suppose it goes to something worthwhile like civic enterprise, or to improving cultural appreciation, or to improve his family budget by doing a little moonlighting? Not on your life. Loafing is the chief objective. Anyone who satisfies himself by doing barely enough work to house, clothe and feed his family and becomes complacent has caught the disease of "infirmity of the will" and is doomed to langor and lassitude. He will take his place in the "Great Society of Mediocrity." If his disease continues as it is likely to do, by the lack of his own will, he will become a parasite and a bum, another category of great numbers. If you don't believe it, just look around. You will see people who are paid not to work and to bear illegitimate children. Many people are finding it easier to go on relief than it is to work, which is almost as profitable.

It is my belief that most people are born with ambitions of self-preservation and self-development. If everyone would employ unrestricted use of his faculties and was permitted free disposition of the fruits of his labor, social progress would be unlimited and endless. But such is not the case. There are too many people who live at the expense of others. In warfare, where the victor lives off of the vanquished, this is called "plunder" and this is a good term to apply to the social parasite who lives off the products of the labors of others. Since man is also inclined to avoid pain or discomfort, and labor to some is painful, he will carry out his first instinct of self-preservation by resorting to plunder when this is easier and less painful than work. Sad but very true, this practice is not only currently popular, but also thoroughly legal. It is possible for an individual born in a city hospital, to parents on relief, living in public housing, to attend public schools and to partake of the school's free lunch program. After finishing school, he goes into the army for a period of time. He then goes to a state university. After he graduates, he marries a public health nurse, and buys a home with a veteran's loan. He then gets a loan from the Reconstruction Finance Corporation to go into a business of his own. His first baby is born in the city hospital, and in a few months, our hero buys a farm with the assistance of another veteran's land program. He obtains emergency feed from the government. To end the story, his parents who receive Social Security checks and old age assistance live with him on the farm, which is supplied

with public electrical power and a government constructed fish pond. This sort of thing goes on and has been for a long time.

I do not intend to be unduly critical, and certainly the common lot of man should be socially improved. This should be done by affording opportunities for labor, personal initiative, creative expression and reward for effort and excellence instead of guaranteeing basic security by handouts. When the latter is used there is always deterioration of initiative, energy, productivity and personal integrity. They become malingerers and outright dishonest, decadent and a part of the great society of which I speak, the cult of the "get something for nothing". No civilization can long remain dominant wherever human behavior permits moral values to become secondary to pecuniary aims. This has always been true throughout world history.

The old adages under which I grew up are still true. "Idleness is a crime." "Idleness is the parent of sin and misery." "An idle brain is the devil's workshop." Such thoughts no longer enter into the national philosophy. Many candidates for office, high and low, are forever quoting Abraham Lincoln, but you have never heard one repeat these quotations, "You cannot strengthen the weak by weakening the strong." "You cannot build character by taking away a man's initiative." "You cannot help men permanently by doing for them what they should do for themselves." Lincoln also made some wise and foreseeing statements about the gravest threats to this country and where they will originate. He said, "At what point then is the approach of danger to the country, and where will it originate?" I answer, "If it ever reaches us, it must spring from amongst us; it cannot come from abroad. If destruction be our lot, we must ourselves be it's author and finisher." "As a nation of free men, we must live through all time, or die by suicide." The "Great Society of Mediocrity", plus the parasites and bums, will do just that.

This country is now experiencing the penalties of the half-done job. An era in which there are constant attempts to legislate all facets of enterprise, including our profession, to the level of mediocrity. Truly an age of short cuts and slipshod service. So-called art is not art and so-called music is not music. The person who seeks perfection is ridiculed and is classified as psychopath. One who seeks enlightment is an egghead.

Great effort is being made to socialize our profession, to reduce it to mediocrity—ignoring what has happened in European countries that have tried socialized medicine. The fact that the former King of England came to the United States to have his abdominal aorta replaced by a prosthesis is not significant to the social planners. The fact that Prime Minister Anthony Eden left London, came to the United States to have his common bile duct repaired is ignored. These examples mean only one thing to me, and that is, these men had rather be operated upon by surgeons practicing under a free enterprise system than by their surgeons practicing under their own socialized system which is beginning to show signs of decadence and mediocity after only fifteen years.

Now let's get personal and talk about you. You are here because you wanted to be a physician. You have worked for your goal and you have thus far achieved it without anyone forcing you to do it. Your brain and your will have worked together, and assuming they continue to work together, in all probability you will graduate and become full-fledged physicians with the degree of Doctor of Medicine. Contrary to what you might have heard, the world does not really await you with open arms. You face a society of free men who are highly competitive, who hold tenaciously to their own hard-earned rewards, relinquishing them grudgingly only to those who display ambition, initiative, tenacity and a dash of temerity. To the lazy and unambitious there is a place for you within the already swollen ranks of the "Great Society of Mediocrity." This is not a plea for you to place an egotistical ambition in the forefront of your thoughts. There is no need to constantly seek personal aggrandizement, because it matters little whether you achieve local, national or world fame. The main idea is that you conduct your aim for the accolade of the "first rate" regardless of how minor your station in medicine may seem.

A good diagnostician would tell you that the prime symptom experienced on the path toward first-rateness is a kind of constant restlessness, which produces a feeling of having failed to accomplish all that one really should. By the same token, the main road to mediocrity is associated with a feeling of sedated complacency and perfect tranquility, which becomes an addicting narcotic to the will.

I would like to quote from the lines of "My Creed" by Dean Alfonge—"I do not choose to be a common man. It is my right to be uncommon. I do not wish to be a kept citizen, humbled and dulled by having the state look after me. I want to take the calculated risk, to dream and to build, to fail and succeed. I refuse to barter incentive for a dole. I prefer the challenges of life to the stale calm of Utopia. I will not trade freedom for beneficence, not my dignity for a handout."

Those who can practice this simple healthy philosophy undoubtedly will join the ranks of creative, intellectuals and not the "Great Society of Mediocrity."

EDITORIALS

Medical Facilities in Africa

THE Continent of Africa, for a long time of interest to us only through our church and missionary connections, has, during the past generation, captured the attention of political, industrial and cultural thought in the United States and, for that matter throughout the entire world. The American Medical Association's Department of Science News recently published in the AMA News a series of three articles dealing with the medical phase of Africa's development. A brief review of these observations may be of some interest to all of us.

The United States, an area of 3.6 million square miles, has a population approaching two hundred million people. Covering 6.3% of the world's land area it has 6% of the world's population. Africa, an area of 11.7 million square miles, has a population of 267 million people, roughly one third as densely populated as the United States. We have 177,-300 physicians and 88 Class-A medical schools. Africa has 31,500 physicians and 28 medical schools. This offers a contrast between a country with the best health provisions in the world and a continent having perhaps the poorest medical service in the world.

Of the 31,500 physicians on the Continent it would appear that a very large percentage are employed in government or public health activities, or teaching, with a much smaller proportion engaged in the actual practice of medicine than we would suspect. There are many tropical and sub-tropical ills with which we are not very familiar but which require personal and individual care. These include malnutrition, gastroenteritis, malaria, leprosy, venereal disease, yaws, tuberculosis, tetanus, sleeping sickness, smallpox, and the infections produced by insects and wild animals. With the great prevalance of systemic and malignant diseases the clinical burden is far greater than can be bourne by so sparce a supply of physicians even though they had adequate hospital, instrumental and medicinal supplies.

Physicians from almost all of the religious denominations and health foundations in the United States have contributed much during the past hundred years or more to establish nuclei of medical service and training throughout the vast continent of Africa. Perhaps the largest and most effective of these organizations has been the Rockefeller Foundation with its world-wide interest in epidemic diseases and their control. At the present time this work is being enlarged and intensified by the governments outside of Africa who have an interest in the political ideology to be adopted by the Africian territories, provinces, colonies and protectorates now intent on obtaining their own independence; 33 of these have achieved some independent status during the last decade.

From Scotland came Doctor David Livingston; from Japan, via the U.S., came Doctor Hideo Noguchi; from Alsace, Doctor Albert Schweitzer—the three great personalities who contributed most to the medical development of Africa; and most recently from the United States, Doctor Paul Earle Carlson. These all died at their posts, devoted martyrs to the advancement of health among the natives of the Dark Continent.

We are tremendously occupied with our own medical problems in this the most advanced country of the world and are hard pressed to provide enough physicians for our own expanding needs. Yet we continue to share our knowledge and skill with the world at large. There are more American physicians and nurses laboring abroad now than ever before, not thru the churches alone but in Project Hope, Medico, the American Leprosy Mission and other agencies. This is as it should be. The spirit of Livingston, Noguchi, Schweitzer and

Carlson will be perpetuated by the present and future generations of American physicians—from our great abundance we will give freely to those who have not.

The following table summarizes the principal information on this subject provided by the Department of Science News of the American Medical Association.

SAM A. OVERSTREET, M.D.

Country	Millions of Population	Hospital Beds	Physicians	Medical Schools
Algeria	10.7	40,000	1,600	4
Angola	4.8	9,900	300	0
Basutoland	.8	1,100	50	0
Bechuanaland	.35	1,000	35	0
Burundi	2.7	4,100	20	0
Camaroons	4.8	10,000	130	0
Cent. African Rep.	1.2	1,800	40	0
Chad	2.7	——	50	0
Congo	.86	1,450	60	0
Congolese Rep.	14.0	——	400	2
Dahomey	1.9	——	70	0
Ethiopia	21.8	5,700	200	1
Gabon	.44	——	70	0
Gambia	.28	——	20	0
Ghana	6.7	4,000	300	1
Guinea	3.0	——	150	0
Ivory Coast	3.3	6,500	150	0
Kenya	7.2	10,300	800	0
Liberia	2.5	750	80	0
Libya	1.2	3,700	200	0
Madagascar	5.6	1,300	650	2
Malawi	4.0	5,300	85	0
Mali	4.5	3,000	100	0
Mauretania	.88	300	30	0
Mauritius	.68	3,000	150	0
Morocco	12.3	20,000	1,200	2
Mozambique	7.0	9,300	325	0
Niger	2.9	1,300	50	0
Nigeria	35.0	16,700	1,000	1
Portugese Guinea	.6	1,000	30	0
Reunion	.36	2,800	100	0
Rhodesia	4.0	16,000	625	1
Rwanda	2.7	——	100	0
St. Helena	——	75	2	0
Sao Tome & Principe	.10	375	8	0
Senegal	3.4	3,400	160	1
Seychelles	——	300	9	0
Sierra Leone	2.2	1,200	165	0
Somalia	4.0	3,800	70	0
Somaliland	.08	700	10	0
South Africa	16.0	91,000	8,000	5
South West Africa	.52	——	50	0
Spanish Guinea	.23	1,450	42	0
Spanish Ifni	——	130	6	0
Spanish Sahara	——	200	38	0
Sudan	12.8	12 000	350	1
Swaziland	.3	725	35	0
Tanzania	9.9	17 000	600	0
Togo	1.6	3 200	50	0
Tunisia	4.3	12 000	425	0
Uganda	6.9	9 700	550	1
U. Arab Republic	26.0	57 700	11,400	6
Upper Volta	4.4	2.900	50	0
Zambia	3.5	11.000	275	0
TOTAL	267.98	109,155	31,465	28

ORGANIZATION SECTION

KMA Chooses Dr. Pennington New President-Elect

Robert E. Pennington, M.D., London surgeon, was named president-elect of the Kentucky Medical Association at the second session of the House of Delegates Wednesday evening, September 22, during the KMA Annual Meeting.



Doctor Pennington

Everett H. Baker, M.D., Louisville, was installed as president of the association during the same session. He succeeds Delmas M. Clardy, M.D., Hopkinsville, in office.

Doctor Pennington, a native of London, is a former vice-president of KMA, and for the past year has served as chairman of the Board of Trustees. He received his medical education at the University of Pennsylvania, graduating in 1936.

Following internship at Philadelphia General Hospital, he served as assistant in pathology at Western Reserve University, and from January of 1939 until July 1941 held a fellowship in surgery at the Mayo Foundation. He was a resident in surgery at Mayo Clinic until April, 1942 when he entered service in the U.S. Army. Doctor Pennington received the Bronze Star in 1945 for meritorious service, and was discharged in January, 1946.

Since that time he has been in private practice in London. He is a former secretary of the Laurel County Medical Society, and in addition to membership in the KMA and the AMA, is a member of the Southern Medical Association, the American College of Surgeons, and the Southeastern Surgical Congress.

Newly elected vice-presidents of KMA, chosen at the September 22 session of the House, are; George W. Pedigo, M.D., Louisville, Central; Donald K. Dudderar, M.D., Newport, Eastern; and C. C. Lowry, M.D., Murray, Western.

Charles C. Rutledge M.D., Hazard, was elected a delegate to the American Medical Association following the resignation of Wyatt Norvell, M.D., New Castle. Doctor Rutledge previously served as an alternate delegate. David B. Stevens, M.D., Lexington, was named alternate to fill that vacancy. Re-elected for another two-year term were John C. Quertermous, M.D., Murray, delegate, and William W. Hall, M.D., Owensboro alternate delegate.



Newly named president-elect of KMA, Robert E. Pennington, M.D., London, left, still serving in the capacity of chairman of the Board of Trustees for the 1964-65 associational year, swears in Everett H. Baker, M.D., Louisville, as president for the coming year. Looking on at right is immediate past-president Delmas M. Clardy, M.D., Hopkinsville. The picture was made during the second session of the House of Delegates September 22.



Doctor Jones



Doctor Hayes

Drs. Jones and Hayes Elected To Head Board of Trustees

Hubert C. Jones, M.D., Berea, who has served as a trustee from the Eleventh KMA Trustees District since 1960, was elected chairman of the Board of Trustees at the September 23 meeting of the Board during the KMA Annual Meeting in Louisville. Rex E. Hayes, M.D., Glasgow, was named vice-chairman.

Doctor Jones succeeds Robert E. Pennington, M.D., London, who was chosen president-elect of the association. A 1943 graduate of the University of Louisville School of Medicine, Doctor Jones has been active in KMA affairs for many years and is a member of the Board of Directors of Kentucky Physicians' Mutual. His private practice in Berea is limited to general surgery.

Doctor Hayes, who was a vice-president of the

association from the Western region of the state in 1959 and 1960, succeeds Donald Chatham, M.D., Shelbyville, in office.

Elected as trustees for three year terms were: Joseph R. Miller, M.D., Benton, First District; Henry S. Spalding, M.D., Bardstown, Fourth District; Robert F. Long, M.D., Somerset, Twelfth District; and James W. Archer, M.D., Paintsville, Fourteenth District. Gabe A. Payne, M.D., Hopkinsville, was re-elected trustee from the Second District.



Doctor Brockman



Doctor Greathouse

Drs. Brockman, Greathouse Named To Head House of Delegates

George F. Brockman, M.D., Greenville, was elected speaker of the House of Delegates of KMA at the second session of the House Wednesday evening, September 22, succeeding Garnett J. Sweeney, M.D., Liberty, who declined to run for re-election.

Richard F. Greathouse, M.D., Louisville, will serve as vice-speaker, filling the vacancy left by Doctor Brockman's election as speaker. Terms of both offices are for three years.

Doctor Brockman, who was elected vice-speaker in 1962, has served on a number of committees within KMA, notably the committees on Maternal Mortality, Scientific Assembly, and Public Education. He was chairman of the KMA Building Committee, which directed the planning and construction of the Headquarters office. He has also served as chairman of the Advisory Committee to the Editor of The Journal.

A former delegate to the AMA from Kentucky, Doctor Brockman is also secretary of the Muhlenburg County Medical Society. He was graduated in 1935 from the University of Louisville School of Medicine.

Doctor Greathouse, currently serving as secretary of the Kentucky Educational Medical Political Action Committee, is a past president of the staff of Children's Hospital in Louisville, and is vice-chairman of the Kentucky Chapter of the American Academy of Pediatrics.

He is a former editor of the Jefferson County Medical Society *Bulletin*, and is currently editor of *The Centaur*, official national publication of Alpha Kappa Medical Fraternity. He is a 1947 graduate of the University of Kentucky and received his medical degree from the University of Louisville in 1951.

Nominating Committee Elected

A five man nominating committee to select a slate of KMA general officers for 1966-67 was chosen by the Association's House of Delegates at its September 22 session during the Annual Meeting.

The nominating committee will hold its first meeting at the KMA Interim Meeting April 14 at Cumberland Falls. A chairman will be elected at that time. Members of the Committee are: Harold B. Barton, M.D., Corbin; Ballard W. Cassady, M.D., Pikeville; Irving F. Kanner, M.D., Lexington; W. Vinson Pierce, M.D., Covington, and William T. Rumage, Jr., M.D., Louisville.

Dr. Quertermous in AMA Post

John C. Quertermous, M.D., Murray, KMA delegate to the American Medical Association, has been appointed to chair the reference committee on Legislation and Public Relations at the winter clinical meeting of the AMA in Philadelphia November 28-December 1.

According to information received at press time, Milford O. Rouse, M.D., Dallas, speaker of the House of Delegates, named Doctor Quertermous to head the committee on which he served last year.

Mrs. Jones Chosen President-Elect Of KMA Woman's Auxiliary

Mrs. Raymond E. Jones, Louisville, was chosen president-elect of the Woman's Auxiliary to the Kentucky Medical Association at that organization's annual Meeting in Louisville September 21-23.

Mrs. Jones will suceed Mrs. Robert J. Salisbury, Mt. Sterling, who was installed as president for the coming year. Mrs. J. Jack Martin, 1964-65 president, presided at the meeting held at the Kentucky Hotel.

Other new officers include Mrs. Ballard Cassady, Pikeville, first vice-president; Mrs. Charles Kissinger, Henderson, second vice-president; Mrs. O. L. May, Danville, third vice-president; and Mrs. Robert Stewart, Ashland, fourth vice-president. Also elected were Mrs. James Harris, Paducah, recording secretary; Mrs. James Keith, Lexington, corresponding secretary; and Mrs. William C. Durham, Louisville, treasurer.



Leaders of the KMA Woman's Auxiliary confer during their annual convention, held in Louisville at the same time as the KMA meeting. From left are Mrs. J. Jack Martin, Tompkinsville, outgoing president; Mrs. Robert J. Salisbury, Mount Sterling, newly installed president; and Mrs. Raymond E. Jones, Louisville, president-elect.



Winners of KMA's highest awards pose with Awards Committee Chairman William Bizot, M.D., Louisville, following their presentation at the September 22 President's Luncheon. From left are W. Gerald Edds, M.D., Calhoun, recipient of the 1965 General Practitioner Award; Doctor Bizot; Mrs. William Brodsky, Louisville, who accepted the R. Haynes Barr Award on behalf of her mother, Mrs. James S. Frankel of Lexington; and J. Duffy Hancock, M.D., Louisville, Distinguished Service Award recipient.

Drs. Hancock and Edds Honored By KMA at Annual Meeting

J. Duffy Hancock, M.D., Louisville, and W. Gerald Edds, M.D., Calhoun, were the recipients of KMA's two highest awards at the President's Luncheon September 22 during the Annual Meeting.

Doctor Hancock, president of the Association in 1953-54, was presented the Distinguished Service Award, and Doctor Hall received the Outstanding General Practitioner Award.

This year's R. Haynes Barr Award was given to Mrs. James S. Frankel of Lexington in recognition of her outstanding service in the field of Public Health. Mrs. Frankel was in Japan at the time of the meeting. Her daughter, Mrs. William Brodsky of Louisville, accepted the award on her behalf.

A general surgeon, Doctor Hancock is a past president and councilor from Kentucky to the Southeastern Surgical Congress and a former president of the Kentucky Surgical Society. He is a member of the Board of Trustees of the Southern Medical Association, and a past chairman of the National (Medical) Advisory Committee of the Social Security Administration, for which service he received the "Director's Citation".

Doctor Hancock, a clinical professor of surgery at the University of Louisville School of Medicine, where he was graduated in 1921, has been president of the Kentucky Physician's Mutual and is currently a member of the Board of Directors. A recipient of the Distinguished Service Cancer Medal, he is a member and past president of the Board of Directors of the Kentucky Division of the American Cancer Society.

Chairman of the McLean County Board of Health since 1953, Doctor Edds was instrumental in providing the new Health Center, which opened in 1958, and in expanding medical services. In 1957 Doctor Edds, with other interested citizens, began working for a hospital in the county, which is now in operation.

A trustee from KMA's Second Trustee District, Doctor Edds last year was appointed to a four-year term on the Board of Regents of Western Kentucky State College. He has been president of the Calhoun Lions Club, and a member of the City Council.

Mrs. Frankel, one of the founders of the Lexington Deaf Oral School in 1961, has been a leader in providing educational opportunities for the deaf children in her community. A graduate of Wellesley College, she was a member of the evaluating committee at the School for the Deaf at Danville for the Department of Special Education at Frankfort. In addition to her valuable work with the deaf, Mrs. Frankel has been very active in other civic, social, and religious groups.

KEMPAC, AMPAC Schedule Political Workshop Nov. 15

A political action workshop for physicians in Kentucky's Third Congressional District (Jefferson County) will be held by the Kentucky Educational Medical Political Action Committee and the American Medical Political Action Committee November 15 at the Medical Arts Building in Louisville.

Representatives Tim Lee Carter, M.D., Tompkinsville, Republican from Kentucky's Fifth District, and Horace R. Kornegay, Democrat from Greensboro, N.C., serving the Sixth District of his state, will be among the featured speakers.

Hoyt D. Gardner, M.D., Louisville, and James H. Sammons, M.D., Highlands Tex., both members of the AMPAC Board of Directors, will represent the national organization. Also attending from AMPAC will be James Imboden, Columbus, O., field representative for this area, and Mrs. Lee Ann Elliott, assistant director of AMPAC, Chicago.

Reservations for the dinner meeting, which starts at 7 p.m., may be made through the office of the Jefferson County Medical Society. The workshop will begin at 8 p.m. For further information contact KEMPAC headquarters at 3532 Janet Ave., Louisville, Ky., 40205; phone 452-3505.

KMA Officers Planning to Attend AMA Clinical Convention

A number of KMA representatives have made plans to attend the American Medical Association's 19th Clinical Convention in Philadelphia November 28-December 1.

Representing the Association will be Delegates J. Thomas Giannini, M.D., Louisville, John C. Quertermous, M.D., Murray, and Charles C. Rutledge, M.D., Hazard.

Alternate delegates also making the trip will be Charles G. Bryant, M.D., Louisville, William W. Hall, M.D., Owensboro, and David B. Stevens, M.D., Lexington. Everett H. Baker, M.D., Louisville, KMA president, will also attend the convention.

A four-day program of lectures, exhibits, motion pictures, color television, fireside conferences, and breakfast roundtables will be presented for the record attendance expected in Philadelphia. The conven-

(Continued on Page 886)

Anatomy of
Low Back Pain #1



the sedentary life is often the seat of low back pain

The human spine is not engineered t
prolonged sitting at desks, pianos, typ
writers and drafting boards. The stress
set up by the heavy, forward-tilted he
and trunk, balanced precariously on
insufficient base, result in strain of t
dorsal musculature, particularly at t
low lumbar level.

*The unusual muscle-relaxant and an
gesic properties of 'Soma'* make it esp
cially useful in the treatment of low ba
sprains and strains. 'Soma' is wide
prescribed ☐ **to relieve pain** ☐ **to rel
muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management
muscle spasm, pain, and stiffness in a variety
inflammatory, traumatic, and degenerative mus
loskeletal conditions. It also may act to normal
motor activity in certain neurologic disturbanc

Contraindications: Allergic or idiosyncratic re
tions to carisoprodol.

Precautions: 'Soma', like other central nervo
system depressants, should be used with caut
in patients with known propensity for taking
cessive quantities of drugs and in patients w
known sensitivity to compounds of similar che
cal structure, e.g., meprobamate.

Side Effects: The only side effect reported with a
frequency is sleepiness, usually on higher th
recommended doses. An occasional patient m
not tolerate carisoprodol because of an individ
reaction, such as a sensation of weakness. Otl
rarely observed reactions have included dizzine
ataxia, tremor, agitation, irritability, headache,
crease in eosinophil count, flushing of face, a
gastrointestinal symptoms.

One instance each of pancytopenia and leu
penia, occurring when carisoprodol was adm
istered with other drugs, has been reported, as h
an instance of fixed drug eruption with carisopro
and subsequent cross reaction to meprobama
Rare allergic reactions, usually mild, have incluc
one case each of anaphylactoid reaction with m
shock and angioneurotic edema with respirat
difficulty, both reversed with appropriate thera
In cases of allergic or hypersensitivity reactio
carisoprodol should be discontinued and appro
ate therapy initiated. Suicidal attempts may p
duce coma and/or mild shock and respirat
depression.

Dosage: Usual adult dose is one 350 mg. tab
three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tabl
and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strain

SOMA
(CARISOPRODOL

Wallace Laboratories, Cranbury, N.
2650

tion is being held in conjunction with the bicentennial observance of the University of Pennsylvania School of Medicine.

An outstanding scientific program has been designed to hold special interest for every practitioner. Some topics to be covered are: ulcerative colitis, gram-negative bacterial infections, medical-surgical review of cardiovascular surgery, and many others.

Drs. Deuschle, Wagner Receive KMA 1965 Faculty Awards

Kurt W. Deuschle, M.D. chairman of the department of community medicine at the University of Kentucky, and Charles E. Wagner, Ph.D., assistant dean and director of admissions and associate professor of anatomy at the University of Louisville, were awarded the 1965 KMA Faculty Scientific Achievement Awards at the President's Luncheon September 22 during the KMA Annual Meeting.

The awards, presented by KMA Awards Committee Chairman William Bizot, M.D., Louisville, were established in 1962. They are presented each year to a faculty member from each of Kentucky's two medical schools in recognition of outstanding research or contributions of equal importance.

Doctor Wagner, who has served as assistant dean at the U. of L. School of Medicine since 1961, received the award as a result of his outstanding role in both teaching and administration. He has been largely responsible for the recently streamlined admissions procedure.

Doctor Wagner, who came to U. of L. in 1952, is regarded as a highly effective teacher as well. He is a graduate of Princeton University and received his Ph.D. from Indiana University.

Doctor Deuschle, a member of the University of Kentucky Medical Center faculty since 1960, was selected as a recipient of the 1965 award for his contribution in a teaching program that has attracted international interest. Under his direction, the Medical Center has embarked on a "Senior Clerkship" program in community medicine, which has proved highly effective.

A graduate of the University of Michigan School of Medicine, Doctor Deuschle previously served on the medical school faculties of the State University of New York, Upstate Medical Center, and Cornell University.

Student AMA Leader Honored

James P. Moss, Williamsburg, Ky., a senior at the University of Louisville School of Medicine, was presented with a special award by KMA this year at the President's Luncheon.

A placque inscribed "In recognition of his outstanding leadership in student activities and high honors he has brought to Kentucky" was awarded to Moss by a vote of the KMA Board of Trustees. Moss was elected last spring as president of the national Student American Medical Association.

Dr. Pennington Named to Health Committee for Appalachia

Robert E. Pennington, M.D., London, president-elect of KMA, has been named to serve on the Advisory Committee on Health of the Appalachian Regional Commission, according to John L. Sweeney, Washington, Federal co-chairman of the Commission.

Doctor Pennington, who was in Washington October 8 for the first meeting of the Committee, is one of a number of members chosen from the health field and the only man in private practice to serve on the recently established board.

The Committee was established by a resolution of the Commission, its purpose being the provision of advise and guidance to the Commission on matters pertaining to health affecting economic development of the Appalachian Region. The group will review the health needs of the region, and develop recommendations concerning the location and organization of health facilities.

Dr. Brockman Now in Vietnam On Volunteer Medical Team

George F. Brockman, M.D., Greenville surgeon and recently-elected speaker of the KMA House of Delegates, left October 4 from Washington enroute to Saigon, South Vietnam, where he will remain for two months as a member of a voluntary medical team providing medical care to the civilian population in that country.

Doctor Brockman, who had attended an orientation program in Washington October 4 before departing, volunteered for service on one team of twenty physicians who will serve in Vietnam under the auspices of *Project Vietnam*.

The American Medical Association, cooperating President Johnson's request for assistance, has appealed to each state and county medical society for participation in the program. *Project Vietnam* will send teams of 20 physicians into Vietnam, later dividing these teams into four groups, each being assigned to a hospital now being operated by the Agency for International Development (AID).

Interested physicians may obtain information and application forms by contacting Project Vietnam, 2233 Wisconsin Ave., N.W., Washington, D.C., 20007.

1966 Annual Meeting Dates Set

September 20, 21, and 22 are the dates scheduled for the 1966 Annual Meeting of the Kentucky Medical Association, to be held again in Louisville.

Headquarters for the meeting will again be the Kentucky Hotel. Scientific sessions and scientific and technical exhibits will be at the Convention Center, as was done this year and in 1964. Everett H. Baker, M.D., Louisville, KMA president and chairman of the Council on Scientific Assembly, met with members of the Council on October 28 to discuss preliminary plans for the 1966 Annual Meeting.



for the comprehensive control of the pain cycle

TRANCO-GESIC®

CHLORMEZANONE with ASPIRIN

100 mg. 300 mg.

Because pain is frequently aggravated and perpetuated by both anxiety and muscular tension, the combination of aspirin with a well tolerated tranquilizer–muscle relaxant (Trancopal® (brand of chlormezanone)) is exceptionally effective.

TRANCOPAL is a "Tranquilaxant" which calms anxiety and tension, relieves muscle spasm, and enhances the analgesic effect of aspirin by subduing *emotional responses* to pain.

NON-NARCOTIC ANALGESIC, with tranquilizing and muscle relaxant properties

In low back pain

sciatica, lumbago; musculoskeletal pain associated with strains and sprains

In tension headache

premenstrual tension and dysmenorrhea

Side effects such as gastric distress, occasional weakness, sedation or dizziness may be noted. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. TRANCO-GESIC should not be administered to persons known or suspected to have an idiosyncrasy to acetylsalicylic acid.

Dosage for adults is usually 2 tablets three or four times daily, the suggested dosage for children from 5 to 12 years is 1 tablet three or four times daily.

Winthrop

Winthrop Laboratories



Philip M. Crane, Ph.D., assistant professor of history at Bradley University, who spoke at the KMA President's Luncheon, is pictured above during his address to KMA members on the evolution of the socialist movement in this country. The luncheon was held September 22 at the Kentucky Hotel in Louisville.

Preserve Tradition of Freedom, Luncheon Speaker Advises

Medicine is one of the last strongholds of the free enterprise system, which is as it should be, president's Luncheon speaker Philip M. Crane, Ph.D., assistant professor of history at Bradley University told approximately 310 people attending the traditional luncheon September 22 during the KMA Annual Meeting.

Doctor Crane, who chose as his topic "The American Dilemma", said that physicians represent a major force trying to preserve the American tradition. Doctor Crane told his audience that Socialism is invading this country without the American people being aware of the situation.

Speaking before a record crowd in the Terrace Room of the Kentucky Hotel, the well-known historian and author traced the growth of Socialism in the United States from its roots in the Intercollegiate Socialist Society early in the century. He cited among his references the names of a number of individuals and groups prominent in U. S. political circles, who are active in the Socialist movement.

Doctor Crane, the author of the book, "The Democrat's Dilemma", taught at Indiana University for three years before going to Bradley. Reports from KMA officers attending the luncheon indicate that it was most successful.



KEMPAC Board Chairman Harold B. Barton, M.D., Corbin, right, and Secretary Richard F. Greathouse, M.D., Louisville, left, pose at the September 20 KEMPAC Seminar with Senators Peter Dominick, second from left, Colorado Republican, and Ralph Yarborough, Democrat from Texas. The Senators were the featured speakers at the Seminar held in conjunction with the KMA Annual Meeting.

Senators Dominick, Yarborough Speak at KEMPAC Banquet

Two views of the future of medicine in relation to the newly passed laws covering medical care for the aged were expressed by Senators John Dominick, Colorado Republican, and Ralph Yarborough, Texas Democrat, the featured speakers at the annual Kentucky Educational Medical Political Action Committee Banquet September 20.

Approximately 200 physicians and their guests attended the banquet at the Kentucky Hotel, held in conjunction with the KMA Annual Meeting.

John Kernodle, M.D., Burlington, N.C., secretary-treasurer of the American Medical Political Action Committee, also addressed the group on "Why AMPAC?" His talk covered the functions and importance of the organization. The diners also heard a brief address by Delmas M. Clardy, M.D., Hopkinsville, 1965 KMA president.

Please Return AMA Questionnaire

County medical society secretaries are urged to complete and return the questionnaire which was distributed by the American Medical Association early in October.

Entitled the "Nationwide Survey of County Medical Society Activities as Reported in 1965", the questionnaire will help establish a comprehensive data center pertaining to county society activities. The results of the survey will be mailed to each county society.

Dr. Fox Named to Health Post

Mary Pauline Fox, M.D., Hazard, health officer for Knott and Leslie Counties, has been appointed regional medical director of the Hazard Regional Health Office. She replaces Dillard D. Turner, M.D., now director of local health services in Frankfort. Doctor Fox will work with health departments in 18 Eastern Kentucky counties in strengthening and coordinating their health services.

Some people get away from colds and sinusitis

by getting away from frigid weather



. . . but if your patient can't get away, relieve sneezing, running nose, and congestion of colds and sinusitis all day or all night with one

ORNADE® SPANSULE® CAPSULE

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Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Summary of contraindications, cautions and side effects: Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction or bladder neck obstruction. Use with caution in the presence of hypertension, hyperthyroidism, or coronary artery disease. Drowsiness; excessive dryness of nose, throat or mouth; nervousness or insomnia may occur on rare occasions but usually are mild and transitory.

Before prescribing, see SK&F product Prescribing Information.

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Dr. Hench, Lexington, Winner Of 1965 Golf Tournament

Richard F. Hench, M.D., Lexington, was the winner of the KMA Championship trophy at the annual Golf Tournament held at the Hunting Creek Country Club in Louisville during the Association's 1965 Annual Meeting.

James B. Douglas, M.D., Louisville, Tournament chairman, announced the winners, who also included Dallas Hagg, M.D., Frankfort, Low Net Winner; Glenn W. Bryant, M.D., Louisville, Senior Division Champion; and Sam A. Overstreet, M.D., Louisville, Low Net Senior Division Winner.

Next year's tournament is tentatively scheduled for Louisville Country Club. All golfers are urged to make plans for participating in the 1966 tournament, to be held Monday, September 19.

Medicare, Fees System, Topics At Fourth District Meeting

Public Law 89-95 (Medicare) and the experiment of establishing by Blue Shield the Prevailing Fees System in one industry were the main topics to be discussed at the November 7 meeting of the KMA Fourth Trustee District at Bardstown, according to Henry S. Spalding, M.D., Bardstown, trustee for the district.

J. Thomas Giannini, M.D., Louisville, KMA delegate to the American Medical Association, who recently attended a special session of the AMA House of Delegates on the subject of Medicare, was one of the featured speakers on the program, outlining the latest AMA policies.

Avil McKinney, director of Hospitals-Physicians Services for Blue Shield, discussed the Prevailing Fees System at the meeting, which was held at the Old Talbott Tavern.

Dr. Wise to be Guest Speaker At Norton Seminar Dec. 16

Robert I. Wise, M.D., Philadelphia, will be the featured guest lecturer at the eighth annual Norton Seminar December 16 in Louisville, according to Robert Lich, Jr., M.D., Louisville, program chairman.



Doctor Wise

The seminar, co-sponsored by Norton Memorial Infirmary and the Kentucky Chapter of the American Academy of Pediatrics, will begin at 10:00 a.m. at Norton Infirmary.

A highlight of the program, Doctor Lich said, will be Doctor Wise's commentary on a collection of colored slides on "Medical Rounds in Northeast Brazil", reported to be of great interest. During the afternoon session, Doctor Wise will discuss "Selection of Therapy in Bacterial Infections".

A number of papers on a wide range of topics will also be presented by speakers from Louisville and the surrounding area. Doctor Lich said that the program is designed to be of value to physicians in almost any phase of medicine. All physicians are cordially invited to attend the seminar. No registration fee will be charged.

Other topics under discussion at the seminar will include pelvic infections, mammography, arrhythmias, ringworm infections, legal psychology, and the diagnostic potentials of urine.



Everett Baker, M.D., Louisville, KMA president, holds a certificate presented at a special ceremony in Danville on September 29 recognizing the KMA McDowell House and Apothecary Shop as a Registered National Historic Landmark. The certificate was presented by Mr. Paul McG. Miller, right, Superintendent of Mammoth Cave National Park. Robert Long, M.D., Louisville, left, member of the AMA Board of Trustees also appeared on the program.

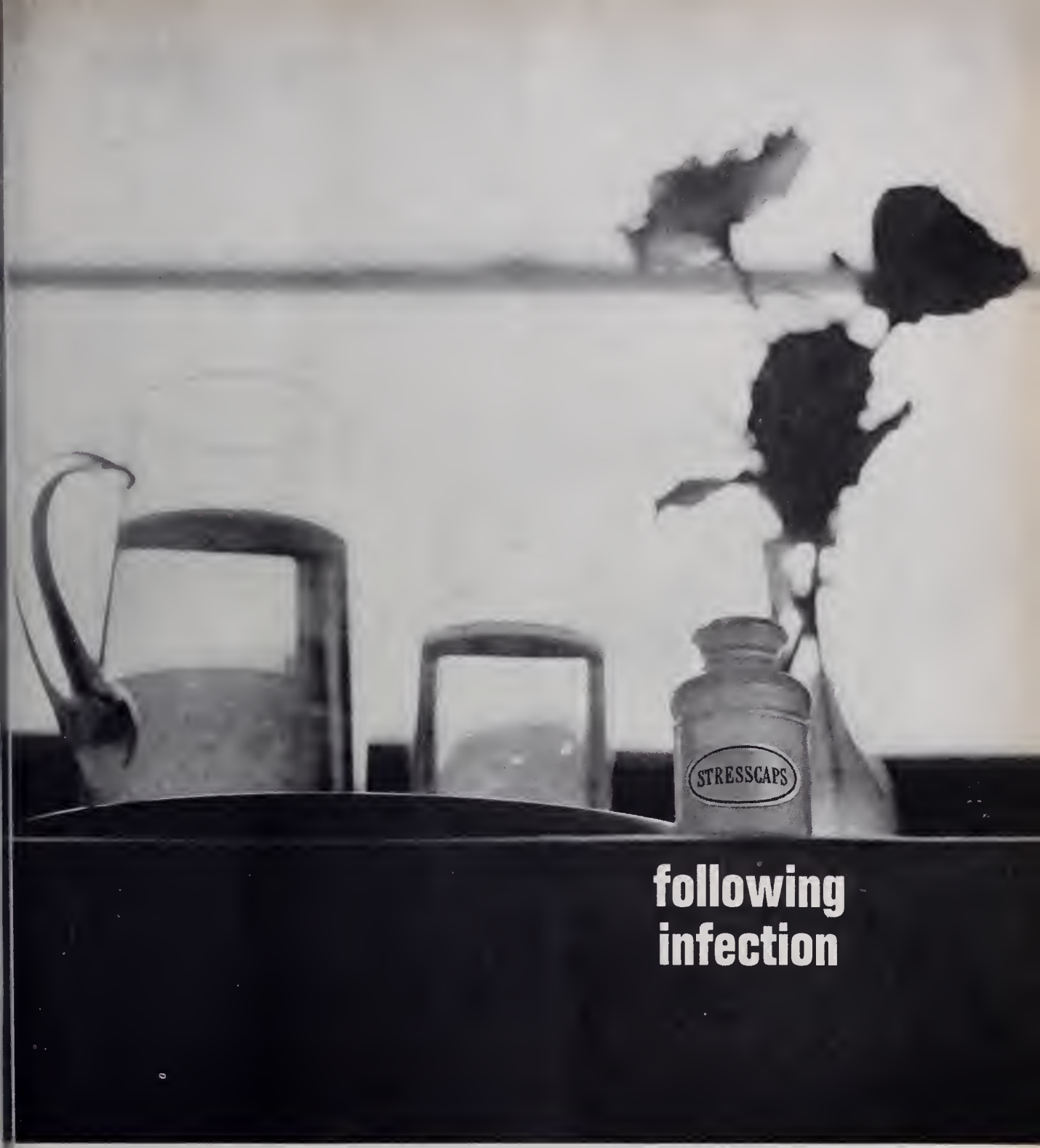
McDowell Home, Shop Designated National Historic Landmark

The KMA McDowell House and Apothecary Shop was recognized as a Registered National Historic Landmark by the U.S. Department of the Interior at a special ceremony September 29 at the McDowell House in Danville.

Laman Gray, M.D., Louisville, chairman of the KMA McDowell House Committee, presided during the ceremony at which the Kentucky Medical Association was presented with a plaque and certificate by Mr. Paul McG. Miller, Superintendent of Mammoth Cave National Park and a representative of the Secretary of the U.S. Department of the Interior.

Some 60 invited guests attended the ceremony on the grounds of the McDowell House. Everett Baker, M.D., Louisville, president of KMA, accepted the awards on behalf of the Association. AMA Trustee Robert Long, M.D., Louisville, spoke on behalf of the American Medical Association.

Mr. George Grider, a representative of the Kentucky Pharmaceutical Association and member of the McDowell House Committee outlined the program for the remainder of the day, which included a dinner at Beaumont Inn in Harrodsburg.



following infection

STRESSCAPS B and C vitamins in therapeutic amounts... help the body mobilize defenses during convalescence...aid response to primary therapy. The patient with a severe infection, and many others undergoing physiologic stress, may benefit from STRESSCAPS.

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FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 (one month's supply) and 100 (three months' supply).

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See picture captions, opposite page



Reference committee chairmen gathered for lunch just prior to joining their committees on Monday afternoon, September 20 following the first session of the House of Delegates. From left, clockwise, are Andrew M. Moore, M.D., Robert T. Longshore, M.D., Richard F. Greathouse, M.D., Garnett J. Sweeney, M.D. (speaker of the House), Douglas Jenkins, M.D., Sam D. Weakley, M.D., George F. Brockman, M.D. (vice-speaker), KMA Attorney Gaines Davis, W. Vinson Pierce, M.D., and E. C. Seeley, M.D.

Was Your Delegate Present?

ROLL CALL—

1965 House of Delegates*

KMA Annual Meeting

OFFICERS

		First Session	Second Session
Speaker	Garnett J. Sweeney	Present	Present
Vice-Speaker	George F. Brockman	Present	Present
President	Delmas M. Clardy	Present	Present
President-Elect	Everett H. Baker	Present	Present
Vice-President	Robert W. Lykins		Present
Vice-President	Harold B. Barton	Present	Present
Vice-President	Kenneth M. Eblen		Present
Secretary	Henry B. Asman	Present	Present
Treasurer	Keith P. Smith	Present	Present
Delegate to the AMA	Wyatt Norvell	Present	Present
Delegate to the AMA	J. Thomas Giannini	Present	Present
Delegate to the AMA	J. C. Quertermous	Present	Present
Alternate Delegate to the AMA	Charles G. Bryant	Present	Present
Alternate Delegate to the AMA	William W. Hall	Present	Present
Alternate Delegate to the AMA	Charles C. Rutledge	Present	Present

TRUSTEES

District			
First	O. Leon Higdon	Present	Present
Second	W. Gerald Edds		Present
Third	Gabe A. Payne, Jr.	Present	Present
Fourth	Dixie E. Snider		
Fifth	Alfred O. Miller		
Sixth	Rex E. Hayes	Present	Present
Seventh	Donald Chatham	Present	Present
Eighth	W. Donald Janney		Present
Ninth	Mitchel B. Denham		Present
Tenth	Douglas E. Scott		Present
Eleventh	Hubert C. Jones	Present	Present
Twelfth	Thomas O. Meredith	Present	Present
Thirteenth	Walter L. Cawood	Present	Present
Fourteenth	William C. Hambley		Present
Fifteenth	Robert E. Pennington	Present	Present

PAST PRESIDENTS

Past President	George P. Archer		Present
Past President	David M. Cox	Present	Present
Past President	Gaithel L. Simpson		
Past President	Richard G. Elliott (deceased)		
Past President	Irvin Abell, Jr.		
Past President	Robert W. Robertson		

DELEGATES

		First Session	Second Session
First District			
County			
BALLARD	Glenn Baird		
CALLOWAY	C. C. Lowry	Present	Present

Picture Captions

See opposite page, reading top to bottom

Delmas M. Clardy, M.D., 1964-65 president of KMA, is shown delivering his president's address to a large crowd in the Convention Center on Tuesday, September 21. Pictured is a portion of the audience who heard Doctor Clardy discuss "Medicine's Finest Hour".

Members of the 1964-65 KMA Board of Trustees pose during the Sunday, September 19 Board meeting prior to the Annual Meeting. From left to right in the front row are: Hubert C. Jones, M.D., Rex E. Hayes, M.D., Delmas M. Clardy, M.D., Robert E. Pennington, M.D., Donald Chatham, M.D., Everett H. Baker, M.D., and Henry B. Asman, M.D. Standing, from left, are: Robert W. Lykins, M.D., William C. Hambley, M.D., George F. Brockman, M.D., Mitchel B. Denham, M.D., Charles G. Bryant, M.D., Thomas O. Meredith, M.D., Kenneth M. Eblen, M.D., W. Donald Janney, M.D., J. Thomas Giannini, M.D., Walter L. Cawood, M.D., Garnett J. Sweeney, M.D., W. Gerald Edds, M.D., Harold B. Barton, M.D., Gabe A. Payne, Jr., M.D., Wyatt Norvell, M.D., O. Leon Higdon, M.D., and Dixie E. Snider, M.D. Alfred O. Miller, M.D., trustee from the Fifth District, was unable to attend the meeting.

A few of those attending the meeting of Reference Committee Number 5, shown in progress above, listen as chairman Louis Foltz, M.D., Louisville, facing the camera at center, discusses a matter with a member of the group. Others pictured at the table are, from left, J. M. Stephenson, M.D., Ashland; W. Vinson Pierce, M.D., Covington, and at right, David A. Hull, M.D., Lexington, and James L. Ferrell, M.D., Paris.

"...it is extremely difficult and sometimes impossible to differentiate between 'pure depression' and anxiety and it is questionable whether depression without a certain degree of anxiety really exists."

Lehmann, H. E., Canad. Psychiat. Assn. J. *4(S)*: 1-12, 1959



An antidepressant designed for the clinical realities of office practice

As many physicians have reported, the large majority of neurotic depressed patients suffer from both depression and anxiety. It may be difficult to decide whether these patients are primarily depressed or primarily anxious. And yet drug treatment of only the symptom which seems more prominent may exacerbate the untreated element of the depression complex.

Consequently, it would seem that therapy specifically aimed at both the depression and associated anxiety and tension should increase success in treatment.

This is one of the important reasons why 'Deprol' has proved particularly helpful. For 'Deprol' acts rapidly both to lift the mood and to relieve the associated anxiety, tension and insomnia.

And side effects, at recommended dosage, have been infrequent and generally readily controlled.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular. CO-5749

Deprol®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

WALLACE LABORATORIES / Cranbury, N. J.



A plaque commemorating his year as president of the Kentucky Medical Association is presented to Delmas M. Clardy, M.D., Hopkinsville, right, by incoming President Everett H. Baker, M.D., Louisville, following the latter's installation at the second session of the House of Delegates on Wednesday evening, September 22.

		First Session	Second Session
CARLISLE			
FULTON	R. W. Bushart		
GRAVES	John Reed	Present	Present
HICKMAN			
LIVINGSTON			
McCRACKEN	James Harris	Present	Present
	W. B. Haley	Present	Present
	R. M. Wooldridge	Present	
MARSHALL	J. R. Miller		Present

Second District

DAVIESS	J. H. Kurre	Present	Present
	John S. Oldham	Present	Present
	W. W. Hall	Present	Present
HANCOCK	B. P. Smith		
HENDERSON	Charles Kissinger	Present	Present
McLEAN	Everett Coleman		
OHIO	George Beard		
	Oscar Allen (Alt)		Present
UNION			
WEBSTER	John A. Logan	Present	Present

Third District

CALDWELL	Ralph Cash		
CHRISTIAN	Guinn S. Cost		
	W. Faxon Payne (Alt)	Present	Present
	Norma T. Shepherd	Present	Present
CRITTENDEN	R. M. Brandon		
HOPKINS	Loman C. Trover	Present	Present
	F. A. Scott	Present	Present
LYON	James E. Hamilton		Present
MUHLENBERG	R. E. Davis		
TODD	R. D. Lynn	Present	Present
TRIGG	Thornton Bryan, Jr.		

Fourth District

BRECKINRIDGE	James G. Sills		
BULLITT	R. S. Bowen		
	J. W. Roney	Present	
GRAYSON	Ralph G. Thomas	Present	Present
GREEN	Kenneth J. S. DeSimone		Present
HARDIN	Fred C. Rainey		
	L. W. Longley (Alt)	Present	Present
HART			
LARUE	Marion Douglass		
MARION	David Drye		
MEADE	George E. Clark		
NELSON	William Yates		Present
	T. G. Forsee (Alt)	Present	
SPENCER	M. H. Skaggs		Present
TAYLOR	Henry F. Chambers	Present	
WASHINGTON	H. B. Simms	Present	Present

Fifth District

		First Session	Second Session
JEFFERSON	Sam H. Black	Present	Present
	McHenry Brewer		
	David Kinnaird (Alt)	Present	Present
	Elbert G. Christian	Present	Present
	Morgan R. Colbert	Present	Present
	Kenneth P. Crawford		Present
	Eugene H. Conner	Present	Present
	John Doyle	Present	Present
	William C. Durham		Present
	Rudy Ellis		
	Louis M. Foltz	Present	Present
	W. C. Gettelfinger	Present	Present
	Richard F. Greathouse	Present	Present
	John Harter	Present	Present
	Walter Hume	Present	Present
	N. I. Handelman	Present	Present
	Hollis Johnson	Present	Present
	G. F. McAuliffe	Present	Present
	R. L. McClendon	Present	
	Clyde Moore	Present	Present
	Herman Moore	Present	Present
	Gerald Peterson	Present	Present
	Henry W. Post	Present	Present
	W. Fielding Rubel	Present	Present
	William T. Rumage, Jr.		
	Samuel M. Smith, Jr.	Present	Present
	William B. Stodghill	Present	Present
	Robert C. Tate	Present	Present
	Edward Warrick, Jr.	Present	Present
	Sam Weakley	Present	Present
	John Wolford		

Sixth District

ADAIR	Oris Aaron		
ALLEN	Earl P. Oliver	Present	Present
BARREN	W. H. Bryant	Present	
	Daryl Harvey (Alt)		Present
BUTLER	John C. Burris		
CUMBERLAND	Robert B. Chambliss		Present
EDMONSON			
LOGAN	C. V. Dodson	Present	Present
METCALFE	P. D. Hitchcock	Present	
MONROE	John C. Marsh		
SIMPSON	L. F. Beasley	Present	Present
WARREN	Paul Parks	Present	Present
	Martin Wilson	Present	Present

Seventh District

ANDERSON	Boyd Caudill	Present	
CARROLL	Edgar S. Weaver		
FRANKLIN	John Stewart	Present	Present
	Harry J. Cowherd	Present	Present
GALLATIN			
GRANT	Daryl B. Shipp	Present	Present
HENRY	Shelby Hicks		
OLDHAM			
OWEN	O. A. Cull		
SHELBY	W. P. McKee		
	Donald Chatham (Alt)	Present	Present
TRIMBLE	Carl Cooper, Jr.	Present	Present

Eighth District

BOONE	L. C. Hess	Present	Present
CAMPBELL-KENTON	Carl J. Brueggeman	Present	Present
	Ronald G. Fragge		
	Thomas Heavern (Alt)	Present	Present
	Paul Klingenberg		Present
	J. R. Stevie	Present	Present
	Richard A. Allnutt		
	W. Vinson Pierce (Alt)	Present	Present
	Robert T. Longshore	Present	Present

Ninth District

BATH			
BOURBON	James E. Ferrell	Present	Present
BRACKEN	J. M. Stevenson	Present	Present
FLEMING	R. W. Fidler		
HARRISON	Henry Moody	Present	
MASON			
NICHOLAS	W. R. Kingsolver		
PENDLETON	R. L. McKenney		Present
ROBERTSON			
SCOTT	J. C. Cantrill	Present	Present

(Continued on Page 900)



FOR YOUR ELDERLY ARTHRITIC PATIENTS...

an effective **GERIATRIC** antiarthritic with

REASSURING SAFETY FACTORS

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention...the enteric coating assures gastric tolerance...and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

Pabalate-SF

In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

—the new, convenient way to prescribe
PABALATE-SODIUM FREE

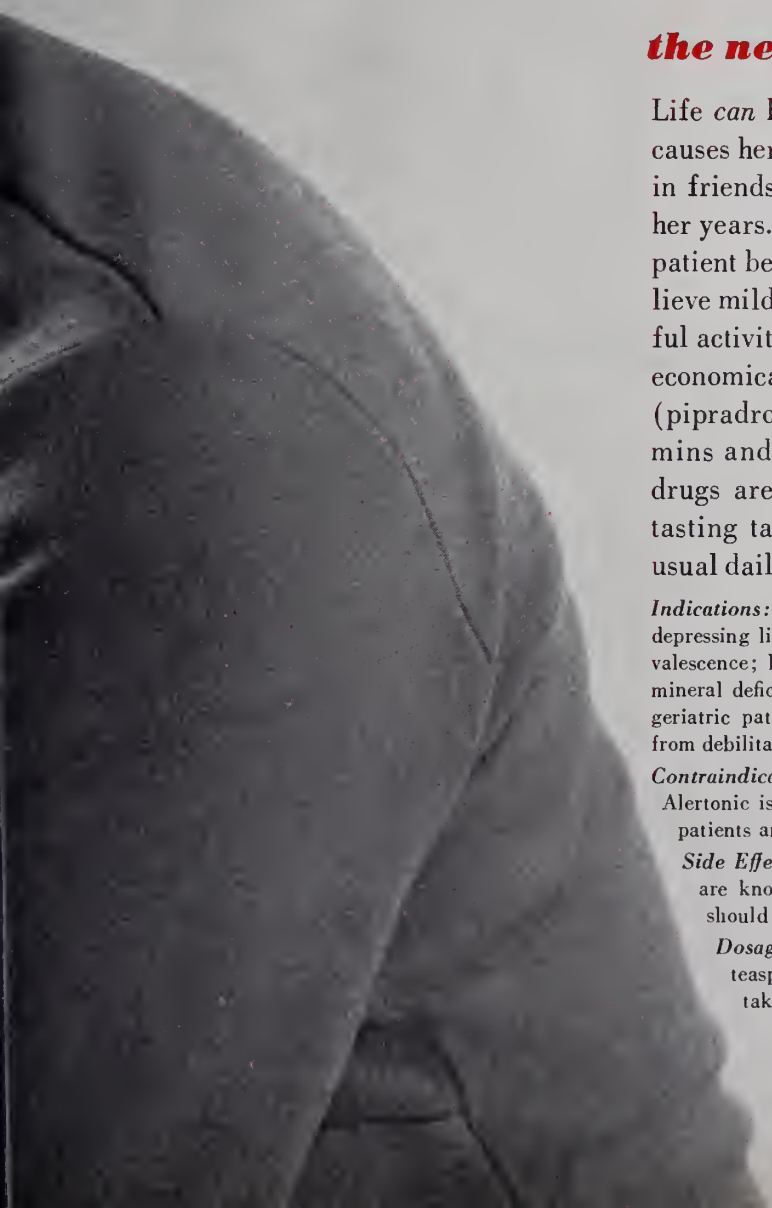
A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA


too young
to be so tired...

revive interest...restore activity promptly with Alertonic®

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline†, 100 mg.; inositol†, 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.



the need for a tonic knows no age

Life *can* begin at forty—except when functional fatigue causes her to feel tired all the time; to start losing interest in friends and surroundings; to look and act older than her years. Alertonic—*a prescription tonic*—can help your patient become her normal self again. Alertonic helps relieve mild depression, revive interest and restore purposeful activity promptly...with a formula that is efficient *and* economical. Alertonic contains a mild central stimulant (pipradrol hydrochloride), 15% alcohol, essential vitamins and minerals. No hormones or MAO-inhibiting drugs are included. No iron. No iodine. One pleasant-tasting tablespoonful before each meal comprises the usual daily dose.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

Side Effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio/Weston, Ontario

Merrell

Tenth District

		First Session	Second Session
FAYETTE	Robert D. Shepard	Present	Present
	N. L. Bosworth		
	Richard D. Floyd	Present	Present
	Carl H. Fortune	Present	Present
	M. R. Gilliam		
	Wm. R. Willard (Alt)	Present	Present
	Andrew M. Moore	Present	Present
	T. R. Bryant, Jr.	Present	Present
	Irvin F. Kanner	Present	Present
	James T. McClellan	Present	Present
	J. H. Saunders	Present	Present
	David A. Hull	Present	Present
	Graydon A. Long	Present	Present
	David B. Stevens	Present	Present
JESSAMINE	J. S. Williams		Present
WOODFORD	Francis Willey	Present	

Eleventh District

CLARK	Thomas E. Averitt	Present	
ESTILL	R. R. Snowden		
JACKSON			
LEE			
MADISON	Douglas Jenkins	Present	Present
	Dwight Blackburn	Present	
MENIFEE	D. L. Graves		Present
MONTGOMERY	R. J. Salisbury	Present	Present
OWSLEY	Mildred B. Gabbard		
POWELL	C. G. Noss		
WOLFE	Paul F. Maddox		Present

Twelfth District

BOYLE	Chris S. Jackson, Jr.		
	John M. Baird (Alt)		Present
CASEY			
CLINTON	Ernest A. Barnes		
GARRARD	O. S. Playforth	Present	Present
LINCOLN	H. I. Frisbie		Present
McCREARY			
MERCER	J. S. Baughman		
	Bacon R. Moore (Alt)		Present
PULASKI	A. L. Cooper	Present	Present
	B. L. Ramsey		
	Stephen B. Kelley (Alt)		Present
ROCKCASTLE	Jack Lewis		
RUSSELL	David L. Lawrence	Present	
WAYNE	John W. Simmons	Present	Present



President-elect Robert E. Pennington, M.D., London, is applauded by fellow KMA members as he walks to the speaker's table following his election at the September 22 session of the House of Delegates.

Thirteenth District

		First Session	Second Session
BOYD	J. E. Stephenson	Present	Present
	W. R. Duff		
	Malcolm H. King (Alt)	Present	Present
	John Ashworth		
	Clyde C. Sparks (Alt)		Present
CARTER			
ELLIOTT	John F. Greene		
GREENUP	Ted Sanders	Present	
LAWRENCE	A. B. Richards	Present	Present
LEWIS			
MORGAN	Morris L. Peyton		
ROWAN	S. E. Reynolds	Present	

(Continued on Page 904)



At the second session of the House of Delegates on September 22, the Fayette County Medical Society requested a recess in order to caucus. In the photo above, David A. Hull, M.D., center, makes a point, as Robert D. Shepard, M.D., left, facing camera, and Andrew M. Moore, M.D., right, with other members of the delegation, listen.

Which Member of the Wedding will have Biliary Dysfunction?

All of them, possibly.

Patients approaching middle age, as well as pregnant women who complain of constipation, belching, and flatulence, with no evidence of organic disease may be suffering from functional disturbance of the biliary tract.

Often, these basic disturbances can be corrected by a single convenient and effective medication: Neocholan.

Neocholan is more than a laxative. It combines all the ingredients for the total management of functional biliary stasis in one tablet. Dehydrocholic acid stimulates the production of thin, free-flowing bile. Bile salts promote better digestion to absorb fats and fat-soluble vitamins, and they tend to prevent chronic constipation by maintaining intestinal tone and normal peristalsis. Phenobarbital and homatropine methyl bromide relax intestinal spasm and insure unobstructed passage of bile and pancreatic juice into the duodenum.

Neocholan is contraindicated in patients with glaucoma Use cautiously in elderly patients with urinary retention and reduce dosage if blurring of vision, increase in pulse rate or distressing dryness of the mouth result.

Each tablet contains Dehydrocholic Acid: 250 mg. (3¾ gr.) Bile Extract (Porcine): 15 mg. (¼ gr.); Phenobarbital: 8.0 mg (⅛ gr.) (Warning: May be habit forming); Homatropine Methyl Bromide: 1.2 mg. (1/50 gr.).

NEOCHOLAN

Dow **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis.





Look, Doctor, what he needs is a shot of penicillin.

Maybe. Maybe not. In any case, he needs something to control his cough.

If it's the useless, exhausting type of cough that often accompanies respiratory infection or allergy, you can provide prompt relief with Novahistine DH. Its decongestant-antitussive action controls frequency and intensity of cough spasms without abolishing cough reflex. And the fresh, grape flavor of Novahistine DH appeals to children and adults alike.

When your diagnosis is bronchitis, complicated by thick tenacious exudates, Novahistine Expectorant is particularly useful. It not only provides decongestive action and controls the cough, but also encourages expectoration, thus easing bronchial obstruction.

Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Ambulatory patients should be advised that drowsiness may result. Continuous dosage over an extended period is contraindicated since codeine phosphate may cause addiction.

Each 5 ml. teaspoonful of Novahistine DH contains phenylephrine hydrochloride, 10 mg., chlorpheniramine maleate, 2 mg., codeine phosphate, 10 mg. (Warning: may be habit forming), chloroform (approx.), 13.5 mg., l-menthol, 1 mg., Alcohol 5%. Each 5 ml. of Novahistine Expectorant contains the above ingredients and, in addition, glyceryl guaiacolate, 100 mg.

NOVAHISTINE® DH

NOVAHISTINE® EXPECTORANT

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, U.S.A. DOW

Founded in 1904

HIGHLAND HOSPITAL, INC.

ASHEVILLE, NORTH CAROLINA
Affiliated with Duke University





A non-profit, psychiatric institution, offering therapeutic milieu, group and individual psychotherapy, and standard somatic treatments. Limited day-patient and out-patient services. The hospital is located in a 75-acre park amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation.

Contact: Medical Director, Highland Hospital, Asheville, N.C. 28801



11:47 pm **11:53 pm** **12:06 am**

The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say **things go better with Coke**
TRADE-MARK ®

		First Session	Second Session
Fourteenth District			
BREATHITT	F. C. Lewis		
FLOYD	Russell L. Hall	Present	Present
JOHNSON	Ernest Skaggs	Present	Present
KNOTT	M. F. Kelley		
LETCHER	T. M. Perry	Present	Present
MAGOFFIN			
MARTIN	John W. Ford		
PERRY	Mary Pauline Fox	Present	Present
PIKE	B. W. Cassady	Present	Present
Fifteenth District			
BELL	Charles B. Stacy	Present	Present
	M. J. Evans	Present	
CLAY	W. E. Becknell	Present	Present
HARLAN	Henry C. Evans	Present	Present
	Dorne Fischer		
	T. Garrett Craft (Alt)	Present	Present
KNOX	H. L. Bushey	Present	Present
LAUREL	E. C. Seeley	Present	Present
LESLIE			
WHITLEY	R. D. Pitman	Present	Present



Selected as the best scientific exhibit at the 1965 Annual Meeting, the exhibit on "Mammography" pictured above was presented by R. Burke Casper, M.D. Bernard F. Sams, M.D., and Edward N. Maxwell, M.D., all of Louisville. Three other exhibits received Honorary Mention.



New members of KMA hear E. Gaines Davis, Jr., Frankfort, KMA legal counsel, discuss the medico-legal aspects of medicine at the Orientation Course held for their benefit on Monday, September 20 during the KMA meeting. Seated at the table is N. L. Bosworth, M.D., Lexington, who moderated the session. The course will be offered twice yearly—before the Annual and Interim Meetings.



The Registration Desk at the Annual Meeting was a busy place as members crowded around the booth at the Convention Center. A record attendance was set at the 1965 meeting, with a total registration of 2186, besting the previous record of 2151 set in 1957. A total of 1172 members attended the meeting this year, as compared with 1094 in 1957. See Comparative Registration chart, next page.

KMA Records Show All-Time High Membership

Last year at this time it was reported in The Journal that the records of the Kentucky Medical Association membership department showed an all-time high number of active physicians in the state who were active members of KMA and the AMA.

This year another record has been set in membership. Records show total active membership of 2,212, as compared to 2,167 last year. Sixty-four counties in Kentucky show 100% KMA membership. In thirty-seven of these counties, all physicians are members of the American Medical Association.

On the chart below, which includes membership records as of October 20, figures do not include associate or emeritus members.

Number of Active Physicians in Kentucky Counties Who are Members of KMA and AMA

(October 20, 1965)

COUNTIES	ACTIVE PHYSICIANS	MEMBERS KMA	MEMBERS AMA
Adair	8	7	6
Allen	6	5	5
Anderson	3	2	1
Ballard	6	4	4
Barren	23	22	21
Bath	3	1	1
Bell	26	21	17
Boone	12	10	10
Bourbon (*)	15	15	9
Boyd	53	49	49
Boyle	23	16	15
Bracken	5	3	3
Breathitt (*) (**)	3	3	3
Breckinridge (*)	5	5	4
Bullitt (*) (**)	4	4	4
Butler (*) (**)	2	2	2
Caldwell	6	5	5
Calloway (*) (**)	14	14	14
Campbell	58	56	50
Carlisle (*) (**)	2	2	2
Carroll (*)	6	6	5
Carter	3	2	1
Casey (*) (**)	4	4	4
Christian	35	32	32
Clark	16	12	10
Clay (*) (**)	5	5	5
Clinton (*) (**)	3	3	3
Crittenden (*) (**)	2	2	2
Cumberland (*) (**)	2	2	2
Daviess	69	68	65
Edmonson (*) (**)	2	2	2
Elliott	2	1	1
Estill (*) (**)	4	4	4
Fayette	361	292	269
Fleming	5	3	1
Floyd	19	10	9
Franklin	32	27	26
Fulton	10	9	9
Gallatin	1	0	0
Garrard (*)	4	4	3
Grant (*) (**)	4	4	4
Graves (*) (**)	15	15	15
Grayson (*) (**)	6	6	6
Green (*) (**)	6	6	6
Greenup (*) (**)	9	9	9
Hancock	1	0	0
Hardin	28	24	21
Harlan	42	38	34
Harrison (*)	8	8	4
Hart (*) (**)	6	6	6
Henderson	30	26	26
Henry (*) (**)	5	5	5
Hickman (*)	2	2	1
Hopkins	36	33	32
Jackson (*) (**)	1	1	1
Jefferson	796	721	646
Jessamine (*)	5	5	3
Johnson	13	12	12
Kenton	87	84	81
Knott (*) (**)	3	3	3
Knox	7	6	3
Larue	5	4	2
Laurel (*)	10	10	9
Lawrence (*) (**)	7	7	7
Lee (*) (**)	2	2	2
Leslie	3	1	0
Letcher	16	10	9
Lewis (*)	2	2	1
Lincoln (*) (**)	4	4	4
Livingston (*)	3	0	0
Logan (*) (**)	11	11	11
Lyon (*) (**)	2	2	2
McCracken	58	54	51
McCreary (*) (**)	2	2	2
McLean (*)	4	4	0
Madison	27	26	21
Magoffin (*)	2	1	0
Marion (*) (**)	9	9	9
Marshall (*) (**)	9	9	9
Martin (*) (**)	1	1	1
Mason (*)	13	13	10
Meade (*)	4	4	2
Menifee (*) (**)	1	1	1
Mercer	13	12	11
Metcalfe (*) (**)	2	2	2
Monroe (*) (**)	8	8	8
Montgomery	9	6	6
Morgan (*)	4	4	3
Muhlenberg (*)	13	13	12
Nelson	10	9	8
Nicholas (*)	3	3	0
Ohio (*) (**)	7	7	7
Oldham (*) (**)	7	7	7
Owen	3	2	2
Owsley (*) (**)	2	2	2
Pendleton (*)	3	3	1
Perry (*)	16	16	15
Pike	35	25	24
Powell	2	1	1
Pulaski (*)	27	27	26
Robertson	1	0	0
Rockcastle	3	1	0
Rowan	12	10	10
Russell (*) (**)	4	4	4
Scott (*)	7	7	4
Shelby (*) (**)	8	8	8
Simpson (*)	6	6	3
Spencer	4	2	2
Taylor	7	6	6
Todd (*) (**)	3	3	3
Trigg (*) (**)	5	5	5
Trimble (*) (**)	2	2	2
Union (*) (**)	7	5	5
Warren	40	38	35
Washington (*) (**)	5	5	5
Wayne (*)	6	6	5
Webster (*) (**)	6	6	6
Whitley	20	19	18
Wolfe (*) (**)	1	1	1
Woodford	9	6	3
TOTAL	2,487	2,212	2,012

* 100% KMA ** 100% AMA

Note: Report includes teaching staffs at medical schools, physicians in Public Health, Mental Institutions, T.B. Hospital, VA Hospital, etc.

COMPARATIVE REGISTRATION FIGURES

KMA Annual Meetings

	Louisville 1956	Louisville 1957	Louisville 1958	Louisville 1959	Louisville 1960	Louisville 1961	Louisville 1962	Lexington 1963	Louisville 1964	Louisville 1965
KMA Members	923	1094	971	997	1021	996	1014	865	924	1172
Guest Physicians	157	178	166	165	203	194	208	141	157	138
Interns-Residents	105	142	108	128	105	102	102	69	108	132
Medical Students	305	328	269	280	289	237	176	59	128	193
Registered Nurses	15	28	22	34	25	31	59	31	34	27
Exhibitors	218	176	211	200	239	204	232	212	297	297
Guests	108	151	164	86	99	132	123	132	125	172
Technicians— Office Assistants	54	54	45	63	33	57	71	22	61	55
TOTAL ATTENDANCE	1885	2151	1956	1953	2014	1953	1985	1531	1844	2186

House of Delegates Considers PL 89-95, Area-Wide Hospital Planning Other Important Matters During Two Busy Annual Meeting Sessions

The KMA House of Delegates held two busy sessions during the 1965 Annual Meeting. Approximately 85 reports of officers, councils, committees and boards, and resolutions were introduced at the first meeting of the House on Monday, September 20, and acted on at the second session September 22.

Recommendations presented by the 1964-65 KMA president, Delmas M. Clardy, M.D., Hopkinsville, and accepted by the House, included (1), that in an effort to improve communications, the county societies have at least one meeting a year on a program dealing with problems within organized medicine. He urged that KMA officers, delegates to the AMA, and KMA staff be employed in presenting these programs.

Other recommendations presented by the president were, (2), that county societies bill their members for voluntary remittance of KEMPAC dues when sending statement for county society dues, (3), that KEMPAC be given a part on all Trustee District programs, and (4), that doctors and their wives become politically and legislatively knowledgeable so they can individually exert political action. These recommendations were also accepted by the House.

At its second meeting the House concurred in a recommendation of the Hospital Committee that KMA take the lead in forming a voluntary Area Wide Hospital Planning Commission in Kentucky.

Reference Committee Report #3, dealing primarily with matters pertaining to legislation and the new "Medicare" law, PL 89-97, drew a lengthy discussion from members of the House. Final action resulted in having the entire report referred to the KMA Board of Trustees for such action as the Board deems desirable. It was noted that the Board should have more information following the special meeting of the AMA House of Delegates called for October 2 and 3.

The delegates discussed in some length Kentucky's Kerr Mills program; and while favoring the program as a whole, there was considerable opposition expressed to some of the current procedures of implementation.

Also during the second session of the House of Delegates on Wednesday evening, September 22, immediate past president of KMA, George Archer, M.D., Prestonsburg, spoke at the request of the Board of Trustees on the very successful completion of KMA's first Orientation Course. The Orientation Program, held on Monday, September 22, had over 50% of all new KMA members in attendance.

In late evening of September 22, at the close of the long second meeting of the House, Everett H. Baker, M.D., Louisville, was installed as KMA president for 1965-66 and Robert E. Pennington, M.D., London, was chosen as president-elect.

Following Monday's meeting of the House seven reference committees went into session to consider all reports and to formulate recommendations to be presented during the final session Wednesday. Much testimony was heard and some of the committees worked late into the night finalizing their report.

The Board of Directors of the Kentucky State Association of Medical Assistants again served coffee to the House members during a break in the meeting on Monday.

Wednesday's session saw a record 172 delegates registered and in their seats. This complimented the overall registration at the Annual Meeting and attendance at scientific sessions as new records were made in all categories.

Dr. Willoughby to Head EEN&T

James O. Willoughby, M.D., Bowling Green, was elected president of the Kentucky Eye, Ear, Nose and Throat Society at the Society's annual meeting September 23 in Louisville. Doctor Willoughby will be assisted by Edward C. Shrader, M.D., Louisville, secretary.

Diabetes Assn. Elects Officers

William W. Winternitz, M.D., Lexington, associate professor of medicine at the University of Kentucky College of Medicine, was elected president of the Kentucky Diabetes Association at its fourth annual meeting in Louisville September 20. The meeting was held in conjunction with the KMA Annual Meeting.

Lewis Dickinson, M.D., Glasgow, was named president-elect of the organization. Other officers are: First vice-president, Kenneth P. Crawford, M.D., Louisville; second vice-president, Stuart Urbach, M.D., Louisville; secretary, John Selby, M.D., Lexington; and Ben H. Hollis, M.D., Louisville, treasurer. The Association will hold its interim meeting at the University of Kentucky Medical Center in the spring. A date has not yet been set for that meeting.

Medical Services Conference Set

The seventh annual Medical Services Conference, sponsored by the AMA Council on Medical Service, Committee on Medical Facilities, will be held November 27 in conjunction with the AMA Clinical Convention in Philadelphia.

The theme of the conference will be "Medical Staff in Action 1965". For information, write to the American Medical Association, Department of Hospitals and Medical Facilities, 535 North Dearborn, Chicago, Ill., 60610.

M.D. Renamed to Wildlife Post

James C. Salato, M.D., Columbia, was recently reappointed by Kentucky Governor Edward T. Breathitt to serve on the Kentucky Fish and Wildlife Commission. Doctor Salato, a Commission member for several years, is currently serving as chairman of the nine-member board.



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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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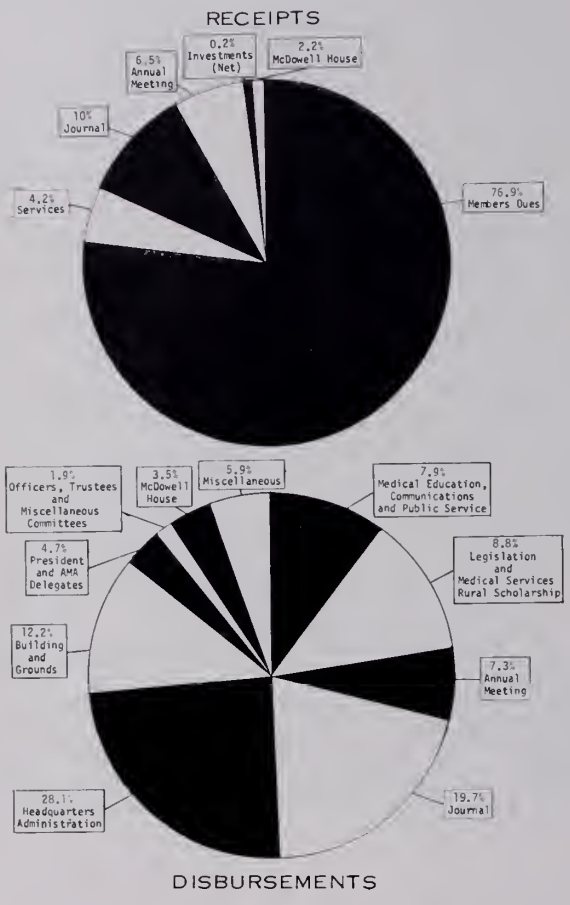
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Graphs Depict Distribution Of 1964-65 KMA Finances

Sources of income and the way its funds are disbursed by the Kentucky Medical Association are shown on the pie-shaped graphs below. These graphs, prepared by the Association's auditors, are based on the 1964-65 fiscal year. If members have any questions, they are urged to contact the Headquarters office.



KMA Council and Committee Reports

Hospital Committee

James B. Holloway, M.D., Lexington, Chairman

KMA Headquarters **September 9, 1965**

The committee heard a report by its chairman of a meeting he had with officials of Blue Cross, Kentucky Hospital Association, and the Kentucky Chamber of Commerce to discuss a state-wide hospital planning commission.

Members of the committee discussed KMA participation in such a voluntary planning commission and made recommendations to be considered by the Board of Trustees at its next meeting.

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Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
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For full details, see the complete prescribing information.

*Dorhout Mees,E.J.,and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

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KMA Annual Meeting Guests Express Appreciation

"May I take this opportunity of thanking you for your typical Kentucky Hospitality during my visit to Louisville for the Kentucky Medical Association's Annual Meeting. May I assure you that I was most comfortable and enjoyed my stay very much."

Leonard M. Schuman, M.D., Professor, Department of Epidemiology, University of Minnesota School of Public Health

"I enjoyed participating in your meeting"

Jackson A. Smith, M.D., Professor and Chairman, Department of Psychiatry and Neurology, Stritch School of Medicine, Loyola University of Chicago

"I wish to take this opportunity to tell you that I thought the Kentucky Medical Association meeting which I just had the pleasure of attending was one of the finest I have experienced . . . thank you for the honor of exhibiting before the (KMA) 1965 Annual Meeting"

Francis H. Stern, M.D., Philadelphia Scientific Exhibitor

"Many thanks for an interesting and thoroughly enjoyable trip."

Clayton T. Beecham, M.D., Danville, Pa. Secretary, American Assn. of Obstetricians and Gynecologists

"I wish to thank you very much for the consideration the KMA extended me while I was in Louisville in September . . . thank you for inviting me to your meeting."

Thomas D. Brower, M.D., Professor of Orthopedic Surgery, University of Kentucky

"The reception I enjoyed from the Kentucky Medical Association was indeed gratifying. Please convey my appreciation to Doctor Clardy and best regards to the many fine folks I met at the convention."

Philip M. Crane, Ph.D., Assistant Professor of History, Bradley University, Peoria, Ill.

"I thoroughly enjoyed my short visit"

Joseph H. Ogura, M.D., Professor of Otolaryngology, Washington University School of Medicine, St. Louis

"I enjoyed my recent visit to Louisville and the opportunity to participate in the Kentucky Medical Association program."

H. William Scott, Jr., M.D., Professor and Chairman, Department of Surgery, Vanderbilt University School of Medicine

"I greatly enjoyed the meeting of the Kentucky Medical Association and am happy to have been invited to attend."

Edith L. Potter, M.D., Professor of Pathology University of Chicago School of Medicine

"I felt that the (KMA) meeting was very worthwhile scientifically as well as very enjoyable. Perhaps because I agreed with him, I thought that the guest speaker at the (President's Luncheon) gave one of the best speeches I have ever heard."

Richard Chute, M.D., Clinical Professor of Urology, Boston University School of Medicine

"I should like to express to you and to the Board of Trustees of the Kentucky Medical Association my thanks for a most enjoyable time at the Kentucky Medical Association Meeting . . . I appreciate your many kindnesses and the opportunity to meet with many of my colleagues and exchange ideas with them."

K. O. Neumann, M.D., President, Indiana State Medical Association

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NEWS ITEMS

Dan A. Martin, M.D., an internist, has begun practice in Madisonville with the Hopkins County Health Department. Doctor Martin, who was graduated in 1952 from Harvard Medical School, previously was associated with the University of North Carolina School of Medicine at Chapel Hill, N.C.

William B. Cook, M.D., has opened an office at Prestonsburg, where his practice will be limited to general surgery. Doctor Cook, a 1957 graduate of Tufts University School of Medicine, interned at the Ohio State University Hospitals and was a resident for four years at the New England Center Hospital in Boston before completing his residency training at the Memorial Hospital for Cancer and Allied Diseases in New York City.

Elliott Podoll, M.D., Louisville pediatrician, has returned to Louisville following a year in postgraduate training at Boston Children's Hospital and Harvard Medical School. Doctor Podoll was one of four physicians in the United States chosen to participate in the fellowship program, sponsored by the National Institute of Mental Health, on the study of emotional handicaps in children and family interrelationships influencing the child.

KMA Announces Six New Members

Six physicians have become new members of the Kentucky Medical Association, according to the report of the membership department. The record is dated October 18 for the addition of the following names:

George F. Berry, M.D., Lancaster; Joseph Bogess, M.D., Central City; Eugene A. Cooper, M.D., Lexington; Ruth Coppedge, M.D., Hopkinsville; Dorothy Gates, M.D., Berea; and Lyndon S. Goode, M.D., Hopkinsville.

Case Discussion

(Continued from Page 876)

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"Betsy Fund" Started in La.

The Louisiana State Medical Society is soliciting contributions to a "Betsy Fund" to aid physicians whose offices and homes were totally destroyed by Hurricane Betsy. Flood losses, which account for the greatest damage, are not covered by insurance.

Charles B. Odom, M.D., president of the Society, said that at least three members of the Society living below New Orleans were completely wiped out. He pointed out that two of the physicians were young men only in practice for a short time. Interested contributors should make out checks to the Louisiana State Medical Society Betsy Fund, Room 1528, 1430 Tulane Avenue., New Orleans, La., 70112. The public is not being solicited for funds.

Metastatic Carcinoma

(Continued from Page 863)

without delay if permanent paraplegia is to be avoided. Metastatic brain tumors, when solitary and in patients whose general physical condition is good, can be excised with favorable results. Cryohypophysectomy is a new method which will find increasing application in the treatment of disseminated breast cancer.

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COUNTY SOCIETY REPORTS

McCracken

The September 16 meeting of the McCracken County Medical Society was held at Boswell's Restaurant. Mrs. Edna Glenn, director of the Paducah-McCracken County Mental Health Center, addressed the group on the functions and aspirations of the Center.

The main functions, she said, are: 1., follow-up work with patients who have been sent home from the State mental hospitals, 2., to aid the physically, emotionally, and mentally handicapped people of this area, and 3., to help get mental patients out of mental hospitals and back into an active role in society.

Following her presentation, Mr. Joe Mitchell of the Mental Health Center described the goals of the Center in qualifying for an increasing amount of Federal funds. In conclusion, he made a formal request of the president of the Society to appoint and advisory committee to help the Center plan for future expansion, with emphasis on the care of in-patients, as well as a 24-hour emergency service.

Joe Spaulding, M.D., Paducah, president of the Society, asked that the present Mental Health Committee work closely with Mr. Mitchell and Mrs. Glenn in further expanding this operation locally with the hope of getting beds or a section in one of the hospitals as a place for local in-patient care. He asked Leon Higdon, M.D., to act as advisor to the committee.

Following these talks, the business meeting was held. The group discussed the provisional status of new members in connection with the by-law change requested by the Kentucky Medical Association, providing that new members serve in a provisional capacity until they attend an orientation course. The matter was placed in the hands of the Legislative Committee for study, to be discussed at the next meeting.

A discussion of including KEMPAC dues in annual billing for Society dues brought opposition. The motion was made, and carried, that the McCracken County delegate to KMA disapprove this motion if it came up at the KMA Annual Meeting.

A request for money from J. Brennan Cassidy, president of the Student American Medical Association at the University of Louisville was considered, but no action was taken. Doctor Spaulding suggested to members that individual contributions would be appropriate.

Doctor Higdon announced that in view of his recent surgery and past record that he would not run again for trustee from the district. A motion was made that Joseph R. Miller, M.D., Benton, be approached by the delegates to see if he would be interested in this position. The motion was seconded and carried unanimously. McCracken County Delegates will support Doctor Miller, if he agrees to run.

In considering new business it was recommended that a vaccination evaluation program be undertaken in the county. After some discussion, which brought out opposition, the topic was dropped.

The meeting adjourned at 10:05 p.m.



In Memoriam

CHARLES W. JUSTICE, SR., M.D.
Ludlow, Ky.
1898 - 1965

Charles W. Justice, Sr., M.D., 67, of Ludlow, died of a heart attack on September 14 while driving on a Kenton County highway. A general practitioner in the area for 40 years, Doctor Justice was graduated from the University of Louisville School of Medicine in 1924. He was a former staff president at St. Elizabeth Hospital, and was a leader in civic affairs. Among his survivors is a son, Charles W. Justice, Jr., M.D., Ludlow.

LEONARD CHAMPION, M.D.
Lola, Ky.
1884 - 1965

Leonard Champion, M.D., 81, Livingston County general practitioner, died September 14 at his home in Lola following a long illness. Doctor Champion, who had been retired for several years, received his degree from the Medical Department of the University of Louisville in 1909. He had practiced in the Eastern Kentucky coal fields and at Paducah and Henderson before moving to Livingston County. Doctor Champion was a veteran of World War I.

FRED W. RAY, M.D.
Independence, Ky.
1872 - 1965

F. W. Ray, M.D., a general practitioner at Independence for 62 years, died September 26 at a Kenton County rest home. He was 93. Doctor Ray, who graduated from the Cincinnati College of Medicine and Surgery in 1897, had been retired from active practice for many years.

JAMIE P. SCOTT, M.D.
Ashland, Ky.
1907 - 1965

Jamie P. Scott, M.D., 58, Ashland surgeon, died September 28 at a Huntington, W. Va., hospital following a long illness. A past president of the Boyd County Medical Society, Doctor Scott was a graduate of the Medical College of Virginia. In addition to taking an active part in a number of medical organizations, he was a member of several fraternal groups.

CHESTER B. CREECH, M.D.
Middleburg, Ky.
1882 - 1965

Chester B. Creech, M.D., a general practitioner in Casey County and the surrounding area for 54 years, died at a Lexington nursing home on October 1. Doctor Creech, 83, retired in 1961. In 1957 he was honored by his friends and former patients at an appreciation day ceremony marking his 50th anniversary in medical practice. He was a 1907 graduate of the Medical Department of the University of Louisville.

WILLIAM D. REDDISH, M.D.
Lexington, Ky.
1889 - 1965

William Dandridge Reddish, M.D., Lexington, died unexpectedly October 7 following hospitalization for a minor injury. Doctor Reddish, a 1913 graduate of Johns Hopkins University College of Medicine, was a Veteran of World War I. He had practiced in Lexington since that time. He was an active participant in church, civic and community affairs.

PRESTON O. LEWIS, M.D.
(Formerly) Evarts, Ky.
1891 - 1965

Preston O. Lewis, M.D., 74, former Harlan County general practitioner and an emeritus member of KMA, died at a Lexington hospital October 10 following a heart attack suffered at a University of Kentucky football game two days before. He had made his home in Louisville for two years. Doctor Lewis, a 1917 graduate of Vanderbilt University Medical School, was a past president of the Harlan County Medical Society. He was active in community and fraternal affairs, and was well known in Eastern Kentucky politics.

CANDOR G. DEPP, M.D.
Hiseville, Ky.
1876 - 1965

C. G. Depp, M.D., 89, a physician in Barren County since 1905, died October 17 in a Glasgow hospital after a brief illness. Doctor Depp, a 1904 graduate of the old Hospital College of Medicine in Louisville, was an emeritus member of the Kentucky Medical Association. He retired from practice in 1961.

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Interposed Jejunal Segments

(Continued from Page 860)

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(Act of October 23, 1962; Section 4369, Title 39, United States Code)

1. Date of Filing: September 29, 1965.

2. Title of Publication: THE JOURNAL OF THE KENTUCKY MEDICAL ASSOCIATION.

3. Frequency of issue: Monthly.

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8. Known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages or other securities: None.

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OF THE KENTUCKY MEDICAL ASSOCIATION



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Walton M. Edwards, M.D., and Margaret Vermillion, M.D. 947

Clinical Aspects of the Leptospiroses
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DuPont Lodge, Cumberland Falls



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(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. (2) Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. Soc., Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. State Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. 19, July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. 25, No. 12, Dec. 1963.

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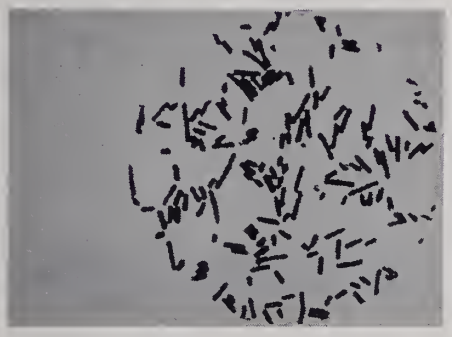
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Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

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MESSAGE FROM THE PRESIDENT



Reflections and Projections

THE year 1965 will go down in history as one of the most eventful in the history of medicine.

Legislation has been enacted which will affect every one of us during 1966. Questions are numerous as to the effects of this legislation. Will the hospitals become overloaded with the chronically ill and the aged? Will some hospital beds be set aside for such emergencies as diabetic coma, perforated peptic ulcer, or the acute coronary? Will hospital review and utilization committees be overworked and will they function effectively in the large city and the tiny community? Will convalescent and nursing homes have sufficient facilities to play a helpful role?

We, as physicians, can answer many of these questions. We are the only ones who can admit patients to the hospital and we decide when the patient is to be discharged. Will pressure be brought to bear to such an extent that we will not be able to exercise our best judgment?

Someone has said, "Prepare for the best, expect the worst and accept what comes". We should prepare for the best, expect the best through dedication, and work for the best.

Robert Burns lamented in complacent surrender when he said,
Still thou art blest, compar'd wi' me
The present only toucheth thee:
But, Och! I backward cast my e'e on prospects drear!
An' forward, tho' I cana' see, I guess an' fear!

May the holiday season of 1965 bring health and happiness and may 1966 be a year of accomplishment with unabating courage and sincerity of purpose under God, the giver of all good gifts.

Everett H. Baker



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Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

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Blue Shield Role in Medicare

THE supplementary medical insurance program of the medicare law provides medical insurance, administered through private carriers, for virtually all elderly people who wish to enroll and pay the required premium of $3.00 per month.

The private carriers are selected by the secretary of H.E.W., who has indicated that his choice will largely depend on the expressed preference of the appropriate state medical society.

The required functions of the agent are to determine the amounts of payments due to physicians and to make these payments, providing that the charges are "Reasonable and customary"; to help providers in applying safeguards against unnecessary utilization agreement as the secretary finds necessary. The other functions which the government may authorize include: to provide consultative services to assist providers in maintaining necessary fiscal records; serving as a channel of communication between the government and providers; making audits of records; and performing other functions as the secretary finds necessary.

It is apparent that the carrier must have a close working relationship with the medical profession. The areas of determining reasonableness of fees and policing utilization are extremely sensitive areas, and will require a staff of experienced professional relations personnel organized to work intimately with practicing physicians. These individuals must understand the local practice of medicine, the relationship between the practitioner and the hospital, between physicians and the local medical society, etc. The carrier should also have the ability to perform statistical analysis, not only on medicare program data, but on community-wide medical-surgical plan data.

There has already been pressure within the medical profession to promote Blue Shield plans as carriers. National Blue Shield spokesmen have indicated their willingness, even eagerness, to serve the medical profession in this highly sensitive role. There are many, however, within the medical profession as well as those in the Blue Shield organization who bitterly remember the long struggle against medicare, and recall only too vividly, the calculated sabotage of the Kerr-Mills program by H.E.W. These men have misgivings about the medicare program and deep distrust for the officials who will administer it.

Blue Shield does perfectly fulfill the criteria of "private carrier" outlined in the law, but as many have pointed out, Blue Shield would also fulfill the criteria for a perfect scapegoat when confusion and discord develop in the program's operation. Arthur E. Hess of the Social Security Administration has described the administration of the program as " shared responsibility" between private agencies and his department. This could mean that Mr. Hess will take credit for all that goes well and the private carrier will be blamed for the foul-ups, of which there will be many. The law, an enormous conglomeration of complicated regulations, will require not only grudging compliance from the medical profession, but wholehearted and devoted cooperation in order to achieve even minimal workability.

If the program does not function smoothly after a short period of time the law itself will not be blamed, nor will the government officials. The private carrier will be the obvious first target for acrimonious "vows releases" and eventual dishonorable discharge. The secretary of H.E.W. may terminate any contract with a private carrier at any time "if the carrier has failed to efficiently and effectively administer the program".

Blue Shield was established by the medical profession and has served as its economic arm for more than a quarter century. Each plan is approved by the local medical society. The members of the society sit on plan boards and have a direct hand in shaping Blue Shield policies. Blue Shield is prepared to serve in a carrier role if this is medicine's wish, and in this role would truly become a shield between physicians and government. In making a decision we must remain aware of the facts of bureaucratic life and the potential damage to the Blue Shield organization.

WILLIAM W. HALL, M.D.





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Contraindications: Hyperexcitable and prepsychotic states; patients hypersensitive to meprobamate.

Side Effects: Occasional allergic skin reactions may occur with meprobamate, accompanied by fever, nonthrombocytopenic purpura, angioneurotic edema, hypotension, or bronchial spasm. Drowsiness with or without ataxia and/or alteration in visual accommodation may occur. Effects of alcoholic beverages may be increased by meprobamate. Use with caution in patients with coronary or cardiovascular disease or severe hypertension. Prolonged use may result in dependence. Reactions can occur if drug is not withdrawn gradually.

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Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage
Initially, give 400 mg. daily (one capsule q.i.d), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. Butazolidin alka contains antacids and an antispasmodic to minimize gastric upset.

Note: The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

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. . . are relieved by direct musculotropic action with

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Available in 100 milligram pink sugar-coated tablets.

The high therapeutic index permits dosage sufficient to relieve spasm promptly. The usual initial dose is 4 tablets. Maintenance dosage is usually one or two tablets 4 times a day.

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BETA-DIETHYLAMINOETHYL DIPHENYLTHIOACETATE HYDROCHLORIDE

. . . directly relaxes smooth muscle spasm
. . . combats hypermotility
. . . non-mydriatic – may be used in glaucoma

Trocinate (Thiphenamil HCl) has been found in three clinical studies, (J. Mo. Med. Assoc., 48:685-6; Med. Rec. & Annals, 43:1104-6; J. Urol., 73:487-93), to be effective and to be free of side-effects. Fifteen years of wide clinical usage has affirmed the safety and effectiveness of Trocinate.

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To Our 1965 Advertisers

AS THE END of the old year draws nearer, we on the staff of The Journal would like to express our appreciation for the support which you, our advertisers, have given us during 1965.

YOU HAVE made it possible, through your valuable contributions, for us to present our members with the latest scientific and technical information so necessary in the practice of medicine. With your continuing help, we look forward to making our Journal more attractive, educational, and readable in the coming year.

TO EACH of you, our advertisers, we extend our warmest wishes for a very pleasant holiday season and prosperity in the New Year, 1966.

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pargyline hydrochloride 25 mg. and methyclothiazide 5 mg.

for control of moderate to severe hypertension

Unique combination produces greater antihypertensive effect with lower doses

Eutron is the combination in a single tablet of 25 mg. Eutonyl (pargyline hydrochloride) and 5 mg. Enduron (methyclothiazide). This combination produces greater therapeutic effect than that of either component used alone. Side effects may be milder, too, as dosages are generally lower. The effective dosage is usually one tablet, once daily. Tablets are scored for greater dosage flexibility.



Each Eutron tablet contains two proven antihypertensives in the ratio shown to be most effective in most patients.

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New **EUTRON** extends your range of treatment in moderate to severe hypertension



A single product you can use even in the presence of congestive heart failure or edema

Eight out of 10 patients respond

In clinical trials, Eutron produced normotension or a significant reduction in blood pressure in eight out of 10 patients studied. The rationale for the product is this: Eutonyl used alone is a potent antihypertensive. Its antihypertensive action is markedly enhanced by Enduron, a potassium-sparing thiazide.[1,2,3] The combination (Eutron) thus produces greater antihypertensive effect with lower dosages of the Eutonyl component, and milder side effects may be seen.

512214

1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.

2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.

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BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.

Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week — maximum reduction in seven to ten days.



Less troublesome side effects may be seen; frequent improvement in "sense of well-being"

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily—that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.

ABBOTT

Prescribing information for **EUTRON**

INDICATIONS: Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.

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In low back pain

sciatica, lumbago; musculoskeletal pain associated with strains and sprains

In tension headache

premenstrual tension and dysmenorrhea

Side effects such as gastric distress, occasional weakness, sedation or dizziness may be noted. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. TRANCO-GESIC should not be administered to persons known or suspected to have an idiosyncrasy to acetylsalicylic acid.

Dosage for adults is usually 2 tablets three or four times daily, the suggested dosage for children from 5 to 12 years is 1 tablet three or four times daily.

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LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y. Lederle

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They're all vulnerable.

Patients approaching middle age, as well as pregnant women who complain of "irregular" constipation, belching, flatulence and indigestion with no evidence of organic disease may be suffering from functional disturbances of the biliary tract.

These basic disturbances can often be corrected by a single convenient and effective medication: Neocholan.

Neocholan is more than a laxative. It combines all the ingredients for the total management of functional biliary stasis in one tablet. Dehydrocholic acid stimulates the production of thin, free-flowing bile. Bile salts promote better digestion to absorb fats and fat-soluble vitamins, and they tend to prevent chronic constipation by maintaining intestinal tone and normal peristalsis. Phenobarbital and homatropine methyl bromide relax intestinal spasm and insure unobstructed passage of bile and pancreatic juice into the duodenum.

Neocholan is contraindicated in patients with glaucoma. Use cautiously in elderly patients with urinary retention and reduce dosage if blurring of vision, increase in pulse rate, or distressing dryness of the mouth result.

Each tablet contains Dehydrocholic Acid: 250 mg. (3¾ gr.); Bile Extract (Porcine): 15 mg. (¼ gr.); Phenobarbital: 8.0 mg. (⅛ gr.) (Warning: May be habit forming.); Homatropine methyl bromide: 1.2 mg. (1/50 gr.).

Neocholan®

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana

DOW



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Lirugen is the most highly attenuated, but fully antigenic, live measles vaccine (Schwarz Strain).[1-8] Additional special passages of the Edmonston Strain resulted in further attenuation which reduces systemic reactions so effectively that the use of gamma globulin with Lirugen is not needed. In recent clinical trials, Lirugen was administered without gamma globulin to approximately 13,000 children. In 1,405 of these children tested serologically, a conversion rate of 99% was reported. Close medical follow-up of inoculated children and controls showed no significant differences between mean maximum temperatures in the two groups. The incidence of high fever (103°F and above, rectally) attributable to the vaccine could be calculated at less than 1%, and the occurrence of mild, transient rash at less than 3%.

Contraindications: Pregnancy; leukemia, lymphoma and other generalized malignancies; brain damage in children under one year of age; febrile illness; allergy to egg proteins, neomycin, or streptomycin. Precautions: Use cautiously in patients with a history of tuberculosis and patients being treated with steroids, irradiation, alkylating agents, and antimetabolites. Consult package literature before administering Lirugen.

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PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, U.S.A. DOW



From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #13-64. A 42 year old, separated, white, gravida 8, para 7, was admitted to the hospital from the emergency room at 3:15 p.m. on May 26, 1964 with the history of vaginal bleeding for several days. The bleeding began as mere spotting, but subsequently developed into an extremely heavy vaginal flow. At the time of admission, the patient was having quite heavy vaginal bleeding in addition to lower abdominal cramps and low back pain. She had missed only one menstrual period. In February, 1959, she was delivered of her seventh child in the hospital; she had no other hospitalizations. There was no history of self instrumentation or other means to attempt abortion.

On admission, the patient appeared to be a middle aged white woman in no acute distress. The blood pressure was 110/80, temperature 96°, pulse 88 and respirations 20. A complete blood count showed a hematocrit of 42 per cent, hemoglobin 13.8 gm., and WBC 19,750, with 84 polymorphonuclear leukocytes, 14 lymphocytes, 2 stab cells. The positive physical findings were limited to the pelvic area. The patient had some suprapubic tenderness without rebound. There were no palpable masses and the bowel sounds were normal. There was a fairly heavy flow of bright blood from the introitus, and the vaginal vault was filled with large amounts of dark clots, together with some bright red blood. The external cervical os was widely dilated with placenta-like tissue protruding through it and a moderate amount of bleeding from the external os. On bimanual examination, the fundus seemed slightly enlarged. The adnexa were normal. The impression was an incomplete abortion.

At 6:30 p.m. on the day of admission, a dilatation and curettage was performed under pentothal anesthesia. Only a small amount of dark colored urine was obtained when she was catheterized prior to the curettage. A large amount of material resembling placental tissue was obtained at operation. A vaginal pack was inserted. The operation was completed at 6:50 p.m., and the patient left the operating room in apparently good condition.

When the patient was returned to her room at 7:05 p.m., she was described as being slightly cyanotic. The blood pressure was 120/75, with a pulse of good quality; the patient seemed to be asleep. At 7:10 p.m., the blood pressure was 118/70, but the patient was not having any vaginal bleeding. At 7:15 p.m., the blood pressure was again recorded as 60/?, the pulse was very weak and the patient was quite cyanotic. Artificial respiration was administered and oxygen was obtained. Adrenalin was given intramuscularly at 7:20 p.m. No blood pressure or pulse was obtainable at this time. She stopped breathing at 7:30 p.m., and was pronounced dead.

An autopsy was performed. The lungs were partially collapsed, and the bronchi contained small amounts of glairy mucoid material and a few small mucous plugs in the smaller bronchi, especially in the lower lobes. The pulmonary tissue in the apical portions of the lungs was moderately wet, and firm. In the lower lobes and in the right middle lobe, the tissues were dark purplish-red, collapsed and airless. Sections revealed dark, purplish-red wet, bloody, airless tissue. The pulmonary arteries and veins were patent. The remainder of the examination revealed no abnormal findings. The final gross pathologic diagnoses were: Probable air embolism, pulmonary atelectasis, pulmonary congestion and edema, and cerebral edema.

Comments

The Committee considered this to represent a direct obstetric death with preventable factors. The terminal event appeared to be an aspiration pneumonitis. Dangers from general anesthesia are constantly present in the management of both normal and abnormal pregnancy and must be guarded against as well as possible.

to help relieve pain in common anorectal disorders

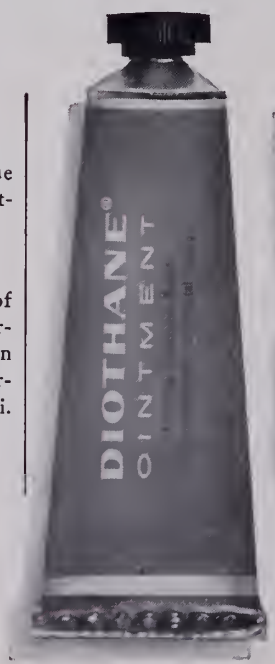
"non-caine" Diothane®

Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form... both are now available.

DIOTHANE OINTMENT

COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

Merrell

THE WM. S. MERRELL COMPANY
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for mild arthritic problems

Schering





when aspirin alone is too little

but full steroid is too much

There's a time for *aspirin*—when the pain and stiffness are almost bearable and easily controlled.... There's a time for full-dosage *steroid*—for limited periods, as in severe arthritic flare-up.... And there's often a time for a moderate formulation of the *two*—when middle-range symptoms, in your judgment, call for middle-range therapy. With SIGMAGEN, your arthritic patients get both anti-inflammatory and analgesic action to relieve inflammation, swelling, pain and stiffness.

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Each tablet contains 0.75 mg. prednisone, 325 mg. acetylsalicylic acid, 20 mg. ascorbic acid, 75 mg. aluminum hydroxide.

Clinical considerations: Precautions—SIGMAGEN Tablets should be used with the same precautions as other corticosteroids. They should not be used in patients with tuberculosis, peptic ulcer, agitated psychotic states, or herpes simplex of the eye. The physician must be watchful in patients with cardiac decompensation, severe hypertension, diabetes mellit renal insufficiency, osteoporosis, and marked emotional instability or psychotic tendency. Acute infections must be controlled with appropriate agents Corticosteroids may mask signs of infection. For more complete details, consult Schering literature available from your Schering Representative or Medical Services Department, Union, N.J. 07083. s.

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A non-profit, psychiatric institution, offering therapeutic milieu, group and individual psychotherapy, and standard somatic treatments. Limited day-patient and out-patient services. The hospital is located in a 75-acre park amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation.

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accurate—comparable to the older standard intradermal tests

practical—can be administered by nurses under physician supervision

convenient—no refrigeration or other storage precautions

economical—stable for 2 years, self-contained disposable unit

Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis. *Available* as the new individually-capped unit, boxes of 5, or in cartons of 25.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle

9635-5



MANAGEMENT OF JUVENILE DIABETES MELLITUS: by Howard S. Traisman, M.D., and Alvah L. Newcomb, M.D.; Published by the C.V. Mosby Company, St. Louis, 1965; 147 pages; Price, $12.75.

This is an indifferently organized and clumsily written book which purports to guide practitioners in the treatment of their young patients with diabetes mellitus.

A desire to impart medical information does not, it should be pointed out to the authors, constitute an exemption from observation of rules of grammatical construction or those pertaining to correct usage of English. One does not "diagnose children with diabetes mellitus," for instance; he diagnoses, or makes a diagnosis of, the disorder. Grade school children learn that tenses are not changed in mid-paragraph without good reason; it is done repeatedly in this offering. There is much word-wasting and needless reiteration of thought. Such inaccurate statements as the following are found not infrequently: "If glucose is discovered in the urine and the reading (sic!) of a blood sugar test done at approximately the same time is elevated, the diagnosis (of diabetes) can be made with assurance."

If one is able to overlook the many ineptitudes of the presentation, the subject matter is found to be neither distinctive nor distinquished. Methods outlined for the treatment of diabetic ketosis are quite acceptable. The chapter on dietary management (written with the co-authorship of a dietitian) considers no approach other than the weighed diet. Though the maintenance of dietary control by this means might be considered by some to be ideal, others, who believe in tempering justice with mercy, would object to the complete absence of consideration of the measured diet. There is quite a bit of discussion of oral hypoglycemic agents, which presently have little place in the management of juvenile diabetes.

This reviewer cannot recommend this book to anyone.

JAMES ROBERT HENDON, M.D.

THE MANAGEMENT OF FRACTURES AND SOFT TISSUE INJURIES: by the Committee on Trauma of the American College of Surgeons; Published by the W. B. Saunders Company, Philadelphia and London, 1965; 354 pages; Price, $7.50.

This is a concise book published in a small volume approximately 5½ by 8½ inches. The objective of the book is to serve as a ready manual to students, residents, and practicing physicians. It accomplishes its objective very nicely.

It begins with an introduction into the general principles of care of open wounds and proceeds from the initial examination to preparation for surgery and prophylaxis against tetanus. The next chapter deals with shock and the various causes and most effective treatment thereof.

The bulk of the book is concerned with the first aid treatment of fractures and gives an outline of the treatment of the various fractures of the body.

On the section concerned with traumatous soft tissues subjects such as burns, lacerations of muscles, tendons and joints are covered. A very useful chapter on the treatment of blood vessel injuries is included. The last few chapters deal with acute injuries to the hand, face, head and neck as well as the emergency treatment of injuries to the eye, chest, and finally, bites.

This is an excellent manual to have in emergency rooms and to have available for medical students and residents. It is not intended to be a definitive all inclusive work but certainly is a fine introduction into the management of acute injuries. The book seems well styled to answer the purpose for which it was designed.

THOMAS D. BROWER, M.D.

HANDBOOK OF PHYSICAL MEDICINE AND REHABILITATION: Edited by Frank H. Krusen, M.D.; Published by W. B. Saunders Company, Phiadelphia and London, 1965; 725 Pages; Price, $16.50.

This book fills a gap that has long been open in the literature pertaining to physical medicine and rehabilitation. It is primarily written for the medical student, intern, resident or practicing physician who is not making physical medicine and rehabilitation his selected specialty. All phases of the field of physical medicine and rehabilitation are gone into; however, in most instances it is written in language which would not require specialized training to understand its meaning. The editor has stated very well what rehabilitation is, "the restoration through personal health services of handicapped individuals to the fullest physical, mental, social, and economic usefulness of which they are capable, including ordinary treatment and treatment in special rehabilitation centers." The co-authors have expounded on special equipment and techniques used and have also outlined methods of treatment which might be carried on outside of special centers. The values of team approach are discussed at length. In brief, the book would probably be useful to any person in the practice of medicine regardless of his chosen specialty field.

I heartily recommend this book as a great effort on the part of some of the outstanding men in the field of physical medicine and rehabilitation to make information available to all specialities without making it so technical as to require a specialist in that particular field to understand it.

ROBERT M. IZARD, JR., M.D.

Anatomy of
Low Back Pain #1



the sedentary life is often the seat of low back pain

The human spine is not engineered fc prolonged sitting at desks, pianos, type writers and drafting boards. The stresse set up by the heavy, forward-tilted hea and trunk, balanced precariously on a insufficient base, result in strain of th dorsal musculature, particularly at th low lumbar level.

The unusual muscle-relaxant and ana gesic properties of 'Soma' make it espe cially useful in the treatment of low bac sprains and strains. 'Soma' is widel prescribed ☐ **to relieve pain** ☐ **to rela muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management muscle spasm, pain, and stiffness in a variety inflammatory, traumatic, and degenerative musc loskeletal conditions. It also may act to normaliz motor activity in certain neurologic disturbance

Contraindications: Allergic or idiosyncratic rea tions to carisoprodol.

Precautions: 'Soma', like other central nervou system depressants, should be used with cautic in patients with known propensity for taking e cessive quantities of drugs and in patients wi known sensitivity to compounds of similar chem cal structure, e.g., meprobamate.

Side Effects: The only side effect reported with ar frequency is sleepiness, usually on higher tha recommended doses. An occasional patient ma not tolerate carisoprodol because of an individu reaction, such as a sensation of weakness. Oth rarely observed reactions have included dizzines ataxia, tremor, agitation, irritability, headache, i crease in eosinophil count, flushing of face, ar gastrointestinal symptoms.

One instance each of pancytopenia and leuk penia, occurring when carisoprodol was admi istered with other drugs, has been reported, as h an instance of fixed drug eruption with carisoprod and subsequent cross reaction to meprobamat Rare allergic reactions, usually mild, have include one case each of anaphylactoid reaction with mi shock and angioneurotic edema with respirato difficulty, both reversed with appropriate therap In cases of allergic or hypersensitivity reaction carisoprodol should be discontinued and approp ate therapy initiated. Suicidal attempts may pr duce coma and/or mild shock and respirato depression.

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Clinical Observations of Rheumatic Fever In the Kentucky Children's Heart Clinic 1950-1964

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Seven-hundred and three patients were registered in the Kentucky Children's Heart Clinic 1950 to 1964 with a diagnosis of the rheumatic state. † One-hundred ten of these were followed for a minimum of five years, and an analysis is presented.

RHEUMATIC fever has been voluminously covered in the literature. The contributions of Cheadle,[1] Coburn,[2] Bland, and Jones,[3] Wilson,[4] Rich,[5] Kuttner,[6] Massal,[7] Ash,[8] and Paul[9] remain paramount.

An analysis of the disease as observed in the Kentucky Children's Heart Clinic 1950-1964 is compared with that of other authors. The data for this paper was extracted from hospital records written by numerous rotating physicians. There was no specific organized plan of evaluation or rigid supervision, and this type of analysis has certain limitations when conclusions are drawn from the notations of numerous physicians. Our analysis does not lend itself to strict comparison with the reports of other authors[3, 11, 13] where organized groups of nurses, statisticians, social workers, physicians and cardiologists participated in long term research projects on this subject. We feel, however, that a survey over a span of 14 years garnered from clinic data of the kind to be presented is a useful contribution.

Clinical Material

The Kentucky Children's Heart Clinic was established in 1950 and is supervised by the Department of Pediatrics, University of Louis-

TABLE I

Registration for Rheumatic Fever, Rheumatic Heart Disease and Chorea in the Kentucky Children's Heart Clinic

Year	Rheumatic Heart Disease	Rheumatic Fever	Chorea
1950	17	31	5
1951	4	28	1
1952	5	32	3
1953	6	40	0
1954	10	3	2
1955	15	32	1
1956	30	22	0
1957	30	30	3
1958	21	28	1
1959	28	21	3
1960	16	27	5
1961	13	26	4
1962	11	28	7
1963	17	20	6
1964[1]	2	9	0
	225	437	41

Total 703

[1] January-June 1964

Average Age anset 8.3 years (youngest patient age 2—oldest age 14)

Sex—54 Male, 56 Female

Race—88 White, 22 Negra

Total Admissions to Children's Hospital of Louisville—77,849 (1953-1963)

Rheumatic Fever Admission Rate to Children's Haspital: 10 per 1000 Admissions (1952-1963)

†*Includes Rheumatic Fever, Rheumatic Carditis, and Chorea*

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TABLE II
Manifestations of Rheumatic Fever

	Present 5eries (percent)	Coburn's 5eries (percent)	U.K., U.S. Joint Report Series (percent)
Arthritis	84	85	43
Carditis	89	65	70
Chorea	9	30	11
Erythemia Marginata	2	17	6
Subcutaneous Nodules	2	14	14
Pericarditis	8		8
Previous History of ..Rheumatic Fever	9		26
Arthritis Only	11		
Carditis Only	23		25
Chorea Only	2		

ville School of Medicine. During the period of 1950-1964, a total of 703 patients registered with a diagnosis of rheumatic fever. (Table 1) Subsequently in 1964, 110 clinic and hospital records were available for patients followed regularly for a minimum of five years; the average follow up was eight years. The discrepancy between 703 patients registered and 110 follow up cases for a minimum of five years is explained on the basis that: 1) Many patients resided outside the Louisville area and remained under the care of private physicians and did not return to the clinic. 2) Many families left the area. 3) The University of Kentucky School of Medicine at Lexington began operation in 1960 and patients from Eastern Kentucky did not have to travel to Louisville.

The clinical findings in these 110 patients are presented and form the basis of this paper.

The diagnosis of rheumatic fever was based on the criteria established by Jones.[10] Patients were seen routinely at intervals of four months being provided free oral sulfadiazine prior to 1955 and oral Bicillin tablets after this date. Occasionally penicillin (Benzathine Penicillin G, 1,200,000 units by monthly injection) was administered parenterally when it was felt that oral medication was unreliable. All patients received a complete clinical and social evaluation and throat cultures for beta hemolytic streptococcus were obtained at each visit. Antistreptolysin titres, C reacive protein determinations, chest films aand fluoroscopy, electro-cardiograms, urinalysis and hemograms were obtained frequently.

Clinical Findings

The average age of the patient at the initial attack was 8.3 years. The youngest patient was two years and the oldest 14 years. The sex distribution was not significant, being 54 males and 56 females. As to race, there were 88 white and 22 Negro patients.

Tabulations of the manifestations are listed in Table II and compared with the findings of Coburn[2] and the Cooperative Rheumatic Fever Study Group.[11]

The association and prognosis pertaining to cardiac involvement is shown in Table III and compared with the findings of Bland and Jones.[3] There were 13 patients who on their initial visit had no evidence of cardiac involvement and 97 with carditis. Of the 13 patients with no initial carditis, one subsequently developed heart disease. Of 97 patients who presented with carditis, 39 (40%) had no evidence of carditis after five years and 58 (60%) had a persistence of carditis after five years. There were seven deaths and the average time from onset until death was 3.7 years.

Initial complications and those developing during subsequent years are noted in Table IV and compared with the findings of White.[12] Of the valvular lesions, the mitral valve was most frequently affected (42%). Both aortic and mitral valves were involved in 13% and mitral stenosis occurred in 3%. Isolated aortic valve involvement was not observed. The aortic valve lesion observed was aortic insufficiency. Other complications included subacute bacterial endocarditis, nephritis, hypertension, pericarditis, and congestive heart failure.

TABLE III
Rheumatic Fever-Rheumatic Heart Disease

	No Rheumatic Heart Disease after initial attack Rheumatic Fever	Rheumatic Heart Disease after initial attack Rheumatic Fever	No Rheumatic Heart Disease after initial attack of Rheumatic Fever but Heart Disease appeared later	Rheumatic Heart Disease after initial attack Rheumatic Fever and persisting	Deaths	Years Survived after initial Rheumatic Fever
Original 5tatus of Patients	347*	653*				
	13†	97†				
5tatus of Patients 5-10 years later	72 (11%)*		83 (24%)*	581 (89%)*	202* (20%)	
	39† (40%)		1† (8%)	58† (60%)	7† (6%)	3.7†

*Bland, E. F., Janes, T. D., Circulation, 4-836, 1951
†Present 5eries Herein Reported

TABLE IV
Complications of Rheumatic Fever

Valvular Lesion	Present series (Percent)	Series of P. D White (Percent)
Mitral Valve Only	42	62
Aortic Valve Only	0	5
Aortic and Mitral	13	33
Mitral Stenosis	3	5

Other:

	Number of Cases
Subacute Bacterial Endocarditis	2
Auricular Fibrillation	2
Nephritis	1
Hypertension	1
Congestive Heart Failure	13 (Includes 7 deaths)

TABLE V-a

Recurrences of Rheumatic Fever

	Total Patients Followed	Total Recurrences	Number of Potients with Recurrence	Recurrences In Adequotely Treated Group	Recurrences In Inadequately Treated Group
Present Series	110	62	27	28	34
Irvington House Series	441	48	37	—	—

TABLE V-b
Complications in Patients With Recurrences

	Adequately Treated	Inadequately Treated
Aortic Insufficiency*	8	4
Mitral Stenosis	1	2
Congestive Heart Failure**	2	3
Subacute Bacterial Endocarditis	2	-
Auricular Fibrillation	2	-

*Aortic Insufficiency developed in one patient with no demonstrable clinical evidence of recurrence of the rheumatic state.

**Congestive Heart Failure developed in one patient with no clinical evidence of a recurrence of the rheumatic state.

Twenty seven patients had a recurrence of the disease while on sulfadiazine or penicillin. The total number of recurrences was 62. (Table V-a) In most instances the diagnosis of a recurrence was based on elevated antistreptolysin titres, presence of elevated C reactive protein or an elevated sedimentation rate in a febrile patient with polyarthritis, carditis or chorea. Of 62 recurrences, 28 were among patients adequately treated as judged from the history of taking oral sulfadiazine or bicillin. There were 34 recurrences among patients who were irregular in keeping clinic appointments and who were unreliable in taking their daily medications. It is to be noted that the number of complications were actually less in the inadequately treated patients[9] with recurrences as compared with those adequately treated[15]. (Table V-b)

Congestive heart failure (Table VI) developed in six patients following their initial attacks of rheumatic fever and four of these were in the adequately treated group. Heart failure developed at the time of the initial attack in three patients and in another three, heart failure appeared one to three years after the initial attack.

The patients dying and the interval from the onset of the disease until death, clinical findings, autopsy findings (four of the seven patients) and the mode of death are noted in Table VII.

Discussion

Incidence: Valid statistics on the incidence of rheumatic fever do not exist as the disease is not reportable in most areas of the United States and the diagnosis is often indefinite. There were 703 patients registered with rheumatic fever and 1352 patients registered for congnital heart disease, giving a ratio of 1 : 2 respectively.

Prognosis: The relationship of residual heart disease to rheumatic fever is compared with the findings of Bland and Jones.[3] (Table III) These authors found that in 11% of patients originally presenting with carditis the heart lesions disappeared, whereas we find 40% in our series. Of the 13 patients with no initial cardiac involvement, one developed residual

TABLE VI
Congestive Heart Failure

Patient	Age at Onset of Rheumatic Fever	Cordiac Lesion	Age at Onset of Congestive Heart Failure	Adequate Treatment Received in KCHC*	Years Followed in KCHC*	Carditis Developed or Progressed While Under Treatment In KCHC*
R1	2	MI, AI EH	2	No	5	Yes
R2	6	MI, AI EH	9	Yes	8	Yes
R3	7	MI, MS AI, AF EH	10	Yes	8	Yes
R4	12	MI, AI EH	12	Yes	8	Yes
R5	9	MI, AI EH, SBE	9	No	11	Yes
R6	8	MI, EH	10	Yes	10	Yes

*KCHC—Kentucky Children's Heart Clinic

heart disease within five years whereas Bland and Jones reported 24% of their patients who initially had no cardiac involvement developed residual heart disease. Our findings are in accordance with the data of the Irvington House Series[13] in which it was noted that of 151 patients without initial evidence of carditis, no residual heart disease developed during follow up studies. Of 74 patients in our series who presented with arthritis and carditis initially, 40 (53%) had residual cardiac disease after five years and in 23 presenting initially with carditis alone, 19 (83%) continued to have carditis within five years. The incidence reported in the Irvington House Series is 72% and 77% respectively.

The mortality in our series was 6% and is lower than reported by Bland and Jones[3] (20% in 10 years).

Complications: The complications of rheumatic fever are noted in Table IV. The incidence of valvulitis is compared with the findings of White.[12] No pure aortic valve disease was noted in our series, the mitral valve always being affected initially even though a predominating aortic insufficiency might develop in succeeding years. Other complications listed are not well documented in the literature as to frequency, other than subacute bacterial endocarditis, which accounted for 10% of the deaths reported by Bland and Jones[3] in the pre-antimicrobial era. In our two patients with sub-acute bacterial endocarditis one died and one recovered. Congestive heart failure accounted for 80% of the deaths reported by Bland and Jones,[3] and was present in all of the seven patients here included who died. Auricular fibrillation was present in two paitents and was associated with mitral stenosis.

The incidence of glomerulonephritis as a complication is low.[14] Hypertension is also rare and the one occurrence was not completely investigated as the patient was lost from the clinic at the age of eighteen years.

Recurrences: There were 62 recurrences in 27 patients who had carditis at the time of initial clinic visit and one patient developed carditis among the 13 who did not have carditis initially. The incidence of recurrences appears to be high when compared with statistics of the Irvington House Series[13] in which it was noted that 37 of 431 patients developed a total of 48 recurrences. The latter report emphasized that cardiac damage was present initially in 69% of the 48 recurrences and that patients who were free from carditis prior to a recurrence did not acquire permanent heart damage as a result of recurrences. The benign effects of recurrences of the rheumatic state

TABLE VII
Deaths From Rheumatic Heart Disease

	Age of Onset	Age at Death	Valvulitis	Mode of Death	Autopsy	Adequate Treatment	Remarks	
D1	14	16	MI, MS	CHF	None	No	No treatment prior to registration in KCHC	Member of exodic Religious Cult—age at onset of RF Indefinite
D2	10	15	MI, MS, AI	CHF, AF	MS, AS	Yes	Cardiac Cath. revealed MI and MS. Surgery planned but expired prior to operation	Four hospitolizations prior to death
D3	9	10	MS, MI	CHF	MS, LVH RVH	Yes	Sudden onset of CHF. No previous history of RH	
D4	5	18	MI	CHF	MI, pericarditis	Not treated for one year prior to death	Originally thought to have CHD—no antibiotics	Cardiac Cotheterization revealed Pulmonary Hypertension
D5	7	20	MI, AI, MS EH	Died of surgery for Aortic Valve replacement	None	Yes	Recurrences at age 9, 12, 16	In CHF prior to surgery
D6	7	10	MI, MS, EH	CHF, SBE	None	Yes	Originally considered to have MS due to CHD	No previous History of RF
D7	3	8	MI, EH	CHF	MI, pericarditis	Yes	Nine recurrences	Antibiotics from onset

Abbreviations:
AF — Auricular Fibrillation
AI — Aortic Insufficiency
AS — Aortic Stenosis
CHD — Congenital Heart Disease
CHF — Congestive Heart Foilure
EH — Enlarged Heart
LVH — Left Ventricular Hypertrophy
MI — Mitral Insufficiency
MS — Mitral Stenosis
RF — Rheumatic Fever
RVH — Right Ventricular Hypertrophy
SBE — Subacute Bacterial Endocarditis

noted in patients without previous heart damage have been reported by other investigators in the pre-antimicrobial prophylaxis era.[15] In our series six patients in congestive heart failure had a total of 25 recurrences; however, one patient with combined mitral and aortic valvular disease in severe failure has had no demonstrable recurrences in eight years.

Antistreptolysin titres and C reactive protein determination were not available prior to 1955. The diagnosis of a recurrence therefore was made on clinical grounds with an elevated sedimentation rate, abnormal electrocardiogram or chest films demonstrating cardiomegaly.

The problem of deciding upon the adequacy of treatment in patients provided free sulfadiazine or bicillin always provokes a dispute. The presence or absence of the beta hemolytic streptococcus in throat cultures to substantiate cooperativeness of the patient in taking penicillin or sulfadiazine was used as a measure in the appraisal of adequate versus inadequate therapy.

Manifestations: The manifestations of rheumatic fever and rheumatic heart disease here reported are compared with the findings in the U.K., U.S. Joint Report on Rheumatic Fever.[11] (Table II) The incidence of erythema marginata and subcutaneous nodules in our series is low when compared with the findings in the latter report; however, our incidence of arthritis and carditis is higher. With the exception of the low incidence of erythema marginata, subcutaneous nodules and chorea the findings in our series are in accordance with other reports.[2]

Deaths: Deaths from rheumatic fever and rheumatic heart disease in our series (6%) were higher than reported in the Irvington House Sreies (2.7%). Eleven of the twelve deaths reported in the latter series had severe carditis from the onset and were free from recurrences thereafter. Three of the seven deaths in our series occurred among patients who had carditis from the onset and had no demonstrable recurrences. The other four patients dying had recurrences ranging from one to nine years after the initial onset. In five patients, death was due to congestive heart failure. One patient died at the time of open heart surgery to replace a diseased aortic valve and one died from subacute bacterial endocarditis.

Summary

During the period 1950-1964, 703 patients registered in the Kentucky Children's Heart Clinic for rheumatic fever, rheumatic heart disease and chorea. Clinical records of 110 patients who have been followed for a minimum of five years and treated with daily sulfadiazine or pencillin have been reviewed and the findings compared with those of other authors.

The average age of onset was 8.3 years. The frequency in the Louisville area was high as noted by an admission rate for rheumatic fever of 10 per 1000 to Children's Hospital. The ratio of rheumatic fever to congenital heart disease was approximately 1 : 2.

The predominating major manifestation were carditis (89%) and arthritis (84%). Chorea (9%), subcutaneous nodules (2%) and erythemamarginata (2%) were infrequent when compared with the findings of other authors. In 58 patients with carditis, the mitral valve was most frequently involved (42%) and the aortic and mitral valves concomitantly in 13%. Mitral stenosis occurred in 3%. Aortic valve involvement as an isolated lesion was not present. Other complications included subacute bacterial endocarditis 2%, auricular fibrillation 2%, nephritis 1% and hypertension 1%. Congestive heart failure occurred in 13% and was present in all of the seven deaths from the disease.

There were 62 recurrences in 27 patients, which is higher than reported by The Irvington House Group (48 recurrences in 37 patients).

In all patients developing congestive heart failure, severe cardiac involvement was present from the onset. In patients dying of the disease, the average length of time from the onset until death was 3.6 years with a range from one year to thirteen years. All deaths occurred from congestive heart failure except D_5 who died during open heart surgery for replacement of a diseased aortic valve.

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The Clinical Aspects of the Leptospiroses†*

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Clinical data based on the study of 235 patients infected with six different types of Leptospirae is presented to illustrate the most dominant symptomatology and to emphasize the importance of the infection as a public health hazard.

THE CURIOUS history of the leptospiroses was initiated by Ladouzy's description of a new clinical entity in 1883,[1] and by Weil's report on a severe hepatorenal state of unknown etiology in 1886.[2] Although reports on what was later known as Weil's disease frequently appeared in the European medical literature,[3,8] and French investigators wrote on the possible association of an "aseptic meningitis" with the disease,[9,12] it was not until 1905, that Stimson[13] observed leptospires in kidney sections obtained from a patient who had presumably died of yellow fever in New Orleans. In 1915, Inada and Ido in Japan,[14] and Uhlenhuth and Fromme in Germany,[7] isolated the *Leptospira* from patients with classical Weil's disease (Noguchi, 1917.)[7]

A disease so frequently observed in the temperate zones was to be considered by physicians of this hemisphere as an almost exclusively tropical disorder for the next five decades. Thus, only 293 authenticated cases were reported in the North American literature by 1948,[6] and 500 by 1956.[1] During the past decade, the leptospiroses have been recognized as a public health hazard and as a veritable threat to the United States' economy.[15,30] Increasing interest of public health and veterinary scientists, internists, microbiologists, and pathologists has helped to elucidate the epidemiology, pathogenesis, and diagnosis of the disease.[31,34] It must be emphasized that the discovery of the etiologic agent of pretibial or "Fort Bragg" fever *(L. autumnalis)* represents one of the finest pieces of scientific detective work ever recorded.[35] Recognition must also be given to those engaged in other scientific labours (abbattoir workers, farmers, swineherders, cane cutters, sewer and rice-field workers, and military personnel) who by acquiring the disease under special circumstances, have provided valuable data for a better understanding of the natural course of the disease.[34, 35]

†*Presented at the September 30 General Session of the KMA Annual Meeting in Louisville, 1964.*

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Transmission

The leptospiroses of man consist of a group of clinical disorders of variable severity, and the infections are well established in domestic and selvatic animal hosts with a world-wide distribution.[2,3,4,7] The pattern of transmission from animal to animal, and from animal to man, seldom stops with the human infection. The infection is of utmost importance among rats, dogs, cattle, swine, sheep and horses, etc. and although the rat and dog are the main hosts for *L. icterohemorrhagiae,* it has been shown that the bat, mongoose, jackal, bandicoot, fox, wild cat, raccoon, mole, mouse, vole, shrew, and skunk may be infected with other serotypes. After the invasion of the host's kidney the leptospirae frequently pass into the convoluted tubules whence they are passed in the urine ("animal shedders"). Cattle, dogs and swine may be seriously injured by the infection, while the other animals remain unaffected.

The infection of man and other animals results from direct, or indirect contact with the infected urine. Since the undisturbed mucosa or slightly damaged skin in permeable to the leptospirae, transmission of the disease is governed by contact with the animal's urine; from animal bites or from handling contaminated meat or the animal entrails, either for economical or scientific endeavours. Moist soil, stagnant water, and slowly moving streams favor the survival of the *Leptospirae* for weeks. Since it has been estimated that at least 25% of the dogs in the United States have or have had leptospirosis, and that close to 50% of these are carriers, exposure among children is presumably high. An outbreak of leptospirosis

TABLE 1.
Types of Leptospirae Identified in 73 Cases

Icterohemorrhagiae	55
Djatzi*	7
Djatzi and Icterohemorrhagiae	3
Djatzi and Alexi	1
Alexi*	3
Ballum	2
Grippotyphosa	1
Borincana*	1

* New Serotypes

has been reported in a family who shared with their dog, drinking water contaminated with *L. canicola*.[13]

Though there seems to be some difference in the incidence and intensity of specific organ involvement by the various types of *Leptospirae*, a separate clinical classification is not warranted. The terms canicola fever (*L. canicola*); swamp fever (*L. grippotyphosa*); pomona fever or swineherd's disease (*L. pomona*) and Fort Bragg, pretibial, or seven day fever (*L. autumnalis*), serve only to call attention to certain related circumstances in the patient's life (contact with dogs or swine, a certain location, or a certain occupation, etc.). By the same token, the classical form of the leptospiroses with jaundice has been known as Weil's disease, and when the disease is accompanied by signs of meningeal irritation with laboratory confirmation, it is known as leptospiral meningitis. This subdivision of the clinical picture on the basis of historical and descriptive features is considered artificial, limiting the attention of physicians to special phenomena with disregard to the systemic nature of the disease.[36, 49, 50]

The identification of the *Leptospirae* by culture and by serological studies is essential in the diagnosis of the disease. The knowledge of the prevalence of some serotypes in certain areas may orient the physician to the possible cause of illness. However, our personal experience with 235 cases of the disease produced by 6 different types tends to suggest no noticeable difference of the malady produced by one type as compared with others, with the possible exception of *L. icterohemorrhagiae* which was responsible for most of those presenting with jaundice and renal failure.[36, 50, 51] (Table 1).

The presence of jaundice is a sign of increased severity and of a longer duration of the disease. Renal failure represents a higher mortality among icteric patients. It has been shown that *L. icterohemorrhagiae* and *L. bataviae* infections show a higher incidence of jaundice, and the greatest range of severity in man, varying from the mildest anicteric to the severely icteric and most fatal form of the disease. Infections with *L. pomona, L. ballum, L. grippotyphosa, L. autumnalis,* and *L. canicola* are generally less severe, with a lower incidence of jaundice and renal failure. Infections with more than one serotype are not rarities.[36]

The higher incidence of the disease among the human male is governed by the frequency of exposure to a contaminated environment. The low incidence in both extremes of life may be determined, among other factors, by the infrequency of exposure, or by the development of inmunity among the aged as a result of undetected clinical, or subclinical infection. As milk is leptospirocidal, infection among infants is rare.[13] An asymptomatic incubation period of 7 to 14 days with the growth and multiplication of the *Leptospirae,* and with permeation of all organs, generally follows the initial contact with the organism.

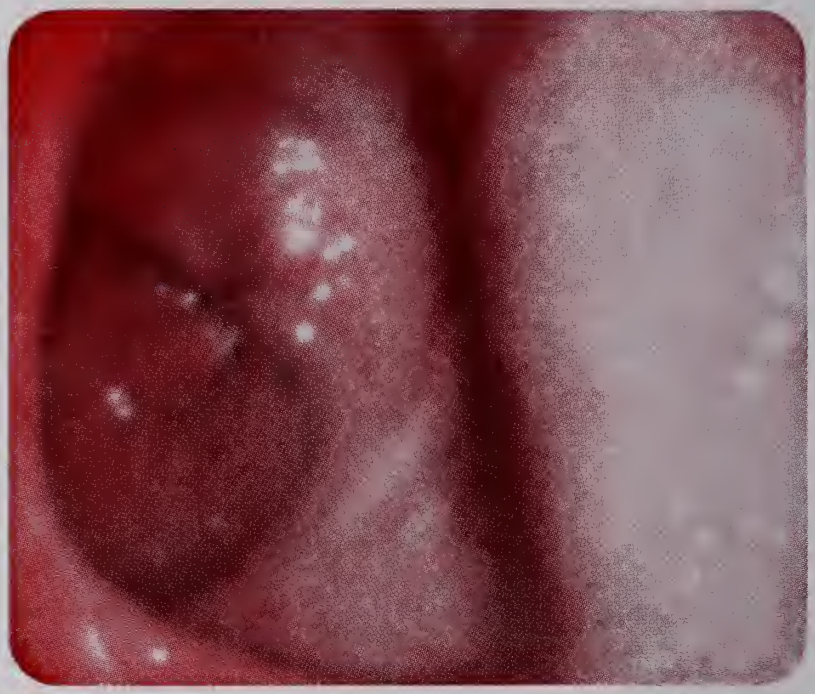
Clinical Picture

Leptospirosis is an acute disease characterized by fever, myalgia, conjunctivitis and headache. It may be accompanied by special features of diagnostic significance such as jaundice, signs of renal failure, and cardiovascular, central nervous system, pulmonary, ocular, hemorrhagic or dermatological alterations.

The onset is generally abrupt and explosive, and many patients vividly recall the exact hour of the appearance of symptoms. The patient develops a shaking chill, accompanied by an overwhelming sensation of malaise with generalized severe body aches and pains and severe headache. Fever follows with severe myalgia accompanied by nausea and vomiting, diarrhea, as well as burning of the eyes and photophobia. Among the uncomplicated cases, this clinical picture persists for 2 to 12 days (usually 6 to 8 days). When jaundice and/or renal failure appear, the duration is longer and more accidental, and the prognosis is graver.

The most common febrile pattern is the saddle-shaped curve. A peculiar secondary rise in temperature may occur in 25% of the icteric cases at the end of the second week of illness and after a 2 or 3 day afebrile interval. This period of "after fever" may last for a few hours to a week, and although generally low grade, it may be as intense as the original episode, and is at times accompanied by the

Intragastric photography studies[1]



A/ E. B., male, age 48. Normal antral contraction. Pyloric opening is not seen. It is difficult to differentiate a deep prepyloric contraction from a "pyloric fleurette" or true pylorus.

B/Same subject after 6 mg. of propantheline bromide intravenously; antral contractions ceased. The pyloric orifice remained open and was easily identified. Better visualization of the antrum was also obtained.



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In addition to the intragastric photographs, cinegastroscopic studies[2] have demonstrated graphically not only its effectiveness but the superiority of Pro-Banthine over belladonna alkaloids.

Pro-Banthine produced complete cessation of gastric, antral and pyloric motor activity with a dose of 6 mg. intravenously. This is approximately one-third the usual oral dose of 15 mg.

Atropine at full normal dosages did not produce such cessation. It required double the usual oral dose of atropine, 0.8 mg. intravenously, to duplicate the aperistaltic action of Pro-Banthine. This dose of atropine produced pronounced discomfort and tachycardia with ventricular rates as high as 150 per minute.

It is this pharmacologic superiority of Pro-Banthine which has made it the most widely prescribed anticholinergic in such conditions as peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

Dosage—The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15 mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily.

Side Effects and Contraindications—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

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TABLE 2.
Leptospiroses: A Clinical Analysis of 208 Cases

Symptams ar Signs	Percentages Whole Graup	Icteric	Anicteric
Fever	99	99	100
Canjunctivitis	99	98	100
Myalgia	97	97	97
Headache	91	95	82
Chills	85	90	84
Pharyngitis	76	87	72
Nausea	75	81	71
Muscle Tenderness	75	79	70
Vamiting	69	76	65
Hepatamegaly	69	80	60
Tachycardia	64	83	64
Jaundice	49	100	0
Burning of Eyes	46	38	54
Diarrhea	27	30	25
Oliguria	25	30	20
Caugh	24	32	15
Pulmanary Findings	24	36	11
Adenapathy	24	12	35
Petechiae and Ecchymases	16	29	4
Hvaatensian	11	14	8
Stiffness af Neck	9	5	12
Hemaptysis	9	14	5
Coma	9	19	0
Canjunctival Hemarrhages	7	12	2
Erythema af Face	7	9	6
Maculapapular Rash	6	10	3
Diastalic Hypertensian	5	8	3
Blaady Diarrhea	3	6	1
Splenamegaly	3	5	2
Hematemesis	3	6	0
Epistaxis	2	5	0
Herpes Labialis	2	2	3

clinical manifestations observed at onset. A milder secondary rise in temperature may appear among the anicteric. Although the pathogenesis of this phenomenon is rather obscure and not attributed to mixed leptospiral or secondary infections, the possibilities of delayed allergic or explosive immunological reactions have been entertained.

The bulbar and palpebral conjunctival injection, at times hemorrhagic, appearing during the first week of illness and persisting for two weeks, is one of the most common findings in *L. icterohemorrhagiae* infections. Burning of the eyes, photophobia and palpebral conjunctivitis are observed in infections with other serotypes. Inasmuch as the latter is a common finding among many infectious diseases, more serious manifestations such as acute uveitis, optic neuritis, retrobalbular neuritis, retinal hemorrhages, keratitis, and various forms of external ophthalmoplegia should be identified. Uveal tract involvement may persist for one year after onset, and although recovery is the rule, serious visual impairment may be encountered among the chronic or relapsing cases in man and animals (especially the horse). Keratic precipitates may be seen on slit lamp examination as early as the fourth day of illness, and an adequate ophthalmological exploration may serve to distinguish the viral from the leptospiral form of hepatitis. We failed to recover the *Leptospirae* from aqueous fluid of the anterior chamber of the eye in 12 instances.[36, 48, 49]

Severe myalgia of the neck, arms, back, thighs and calves accompanied by extreme toxemia, is the second most important clinical finding. Nausea and vomiting and diarrhea, at times bloody, and of variable intensity appear early in the course of the disease. Massive hematemesis may jeopardize the patient's life, since it may lead to an acute vascular collapse and death, or it may seriously aggravate the already precariously affected kidney to the point of death by uremia from a marked diminution in renal blood flow. The marked elevation of serum amylase so commonly observed among the icteric cases is mainly attributed to renal failure, rather than to the acute pancreatitis that may accompany the disease.

Although the pulse rate usually runs parallel to the intensity of fever, a relative bradycardia simulating that of typhoid fever is not uncommon. Hypotension (less than 100 mm. of Hg. systolic) occurs in over 10% of the patients, and is more commonly observed among the severely icteric early in the course of the disease. A pericardial friction rub is occasionally encountered among those with intense jaundice and acute renal failure. Serial electrocardiograms present numerous alterations pointing to subepicardial and intramural injury. [49, 52] (Table 2)

Most authors have reported an incidence of jaundice of 20 to 80% in *L. icterohemorrhagiae* infections.[36, 41, 49, 53] Icterus may appear during the first two weeks of illness, but it is most frequently observed after the third day. Maximal bilirubinemia appears within the first 8 days after the onset of the icterus which may persist from one to 72 days, with an average of 32 days. Pruritus has never been observed in classical Weil's disease, but light colored stools may appear during the earliest phase of icterus. Increased urinary urobilinogen values are generally encountered in both the icteric and anicteric patients before and during the periods of hyperbilirubinemia.

Although the liver may be enlarged (1 to 5 cm.) in 80% of the icteric and 60% of the anicteric cases, the organ is generally soft in consistency and of normal shape. The cephalin flocculation test is strongly positive in 40% of the cases. The serum globulins are remarkably increased in 66% of the icteric and 50% of the anicteric. The thymol turbidity test is disturbed in less than 10% of the cases. The alkaline phosphatase is elevated in one sixth of the

cases. The prothrombin time is seldom altered, and easily corrected with parenteral vitamin K. The serum pyruvic and oxalacetic and glutamic transaminases are elevated in one third of the patients. Cholesterol esterification is disturbed early in the course of the anicteric and icteric cases, but normal values are obtained by the second week. Abnormal bromsulphalein retention is frequently recorded in the earliest phase of the icteric and anicterci disease.[36, 53] Neither extensive cellular necrosis nor symptoms of hepatic coma have been observed in the disease, despite data pointing to a decreased functional capacity of the hepatic cell as the main governing factor in the production of jaundice.[41] The recovery of six patients suffering from compensated hepatic cirrhosis prior to infection with the *L. icterohemorrhagiae* illustrates the apparent preservation of integrity of the hepatic cell even in the severest of cases.[36]

Neurological Manifestations

The various neurological manifestations consist of headache, coma, convulsions, delirium, incoherence, lethargy and stupor. These symptoms are not governed by the severity of jaundice or the functional alterations in the hepatic cell. The appearance of convulsions during the first day of illness is an ominous prognostic sign carrying an extremely high mortality (13 of 19 cases of our series died.[53] It is plausible to suggest that coma is generally associated with renal failure, peripheral vascular collapse from overwhelming toxemia, bacterial complications, or acute and massive blood loss.[36]

Signs of meningeal irritation are frequently elicited, but these are at times reasonably attributed to the accompanying exquisite muscle tenderness. The meningeal involvement requires confirmation by an examination of the spinal fluid for increased proteins, pleocytosis, and the isolation of the *Leptospirae* during the first week of illness.[36, 43, 47] The spinal fluid may be under pressure. The yellow fluid is presumably due to increased permeability of the meningeal barrier, rather than to the hyperbilirubinemic levels. In rare, but most pathetic circumstances, the neurologist and internist are faced with the clinical picture of an acute cerebral syndrome early in the course of the disease and among the anicteric patients, which may prompt the neurosurgeon to useless interventions. Recovery from transverse myelitis and peripheral neuritis is not rare in the disease.

TABLE 3.
Leptospiroses: Laboratory Findings in 208 Cases

	Percentages		
	Whole Group	Icteric	Anicteric
Albuminurio	72	79	64
Azotemio	58	71	42
Leukocytosis	58	69	45
Neutrophilio (over 80%)	43	48	33
Positive cephalin flocculation	42	44	40
Pyurio	36	36	37
Cylindrurio	36	48	24
Anemio	12	15	9
Hemoturio	11	13	9
Prolonged prothrombin time	8	15	0
Leukopenio	3	1	4

It must be emphasized that renal alterations of variable intensity are frequently observed, and that 70% of *L. icterohemorrhagiae* infections produce albuminuria. Cylindruria occurs in one third, and hematuria, in one tenth of the cases. The oliguria with intense azotemia observed early in the course of the disease is best explained on the basis of renal hypoxia, and to the effects of the *Leptospirae* and/or their toxins on the renal tubules. Heroic attempts to induce diuresis during this phase of the disease may lead to death. As far as we know, hemodialysis has not been employed in the management of the acute renal failure observed in the leptospiroses. The most ominous prognostic sign of the icteric form of the leptospiroses is the intense azotemia. However, recovery is frequently ushered in by a copious diuresis of extremely diluted urine, marking the beginning of healing of the tubular lesions. Chronic renal damage has not been observed in leptospiral infections.[37,40] (Table 3).

External or internal blood loss (nasal, gastrointestinal, pulmonary or genitourinary hemorrhages) may lead to anemia. There is no evidence of intravascular hemolysis in man. Although leukocytosis is encountered in 70% of the icteric and 45% of the anicteric patients, leukopenia is not a rarity. The appearance of petechiae and ecchymoses in 30% of the jaundiced and 5% of the anicteric patients is not governed by either significant hypoprothrombinemia, alterations in the bleeding and clotting times, or thrombocytopenia. A rash simulating that of dengue fever, or that with a pretibial distribution is not uncommon in certain epidemics.[35] It appears that hemorrhage derives from ulcerated mucosal surfaces, and from damage of the capillary walls by the direct effect of the organism or their toxin. The additional hemorrhagic factors involved in severe uremia of various etiologies should be considered. Massive hemorrhage is one of the

most common causes of death in the leptospiroses.

Cough occurs in 25% of the cases. This may be productive of both mucus and of various amounts of blood, during the second week of illness. Pulmonary consolidation appears in one third of the icteric patients and is less commonly seen among the anicteric. Patchy pneumonic infiltrates are frequently observed in the X Rays. A pleural friction rub is recorded in 10% of the cases. It must be clarified that the severity of the hemoptysis does not go hand in hand with either the clinical or the roentgenological pulmonary findings; since the anicteric may present with the same severity of hemoptysis as the icteric. Persistence of this phenomenon may endanger the patient's life.[36,42]

The spleen is seldom palpable in *L. icterohemorrhagiae* infections, but considering that this organ may be as soft as a powder puff, its palpation may be difficult. Significant enlargement of the lymph nodes is not rare in both the icteric and anicteric patients. Regional painful lymphadenopathy may lead to the diagnosis of an acute bacterial lymphangitis during the early phase of the disease. Since this phenomena disappear during convalescence to reappear during the period of "after fever", it may serve as basis for the study of the immunological aspects of the disease.

Laboratory Diagnosis

Leptospires may be isolated from spinal fluid and blood during the first 8 days and at times, 14 days of illness. Inasmuch as protoplasmic extrusions of the formed elements of blood are frequently mistaken for the organism, darkfield examination is undependable. Adequate methods for the culture of the *Leptospirae* have been devised.[24, 49, 55, 56] Inoculation of the guinea pig, the Syrian golden hamster, or the field mouse is commonly used for the recovery of the *Leptospirae* from tissue suspensions and from body fluids.[2] Strict isolation must be observed among caged animals, in order to prevent cross infections.

The serological diagnosis of the disease is based on the agglutination-lysis and the complement-fixation tests. Antibodies for agglutination with the leptospiral antigens may appear after the seventh day (generally by the 12th day of illness). Titers of 1:50,000, or more may appear by the second and third weeks of illness. Since measurable levels of leptospiral antibodies may persist for over a year in otherwise healthy humans from endemic areas, a definite diagnosis must be rested upon rising titers during the course of the disease. Since the value of the agglutination-lysis test in the identification of the *Leptospirae* must rest on the use of a wide variety of serotypes to assure detection of antibodies in a given serum, the isolation, culture and identification of the organism is a more exact diagnostic method.

The complement-fixation test has a wider spectrum than the agglutination-lysis test, inasmuch as the use of three antigens obtained from *L. icterohemorrhagiae, L. grippotyphosa* and *L. hyos,* provides for the detection of leptospiral antibodies regardless of the infecting strain. This procedure is as reliable as the agglutination-lysis test and it requires less detailed laboratory work. The test does not yield any information concerning the types of infecting *Leptospirae,* but complement-fixation antibodies may appear as early as the second day (usually within the first 10 days of illness), and it is justified for a prompt diagnosis. Both serological tests are useful in the study of endemicity of the disease.[36]

Differential Diagnosis

Noguchi's false claim of a leptospiral etiology for yellow fever in 1919,[2] illustrates the clinical similarity of the two diseases (classical Weil's disease). Subacute bacterial endocarditis or septicemia may be indistinguishable from the leptospiroses, but evidence pointing to hepatic dysfunction and acute renal failure, and the production of the offending organism by culture represent the main points of differentiation. A case of *Pseudomona aeruginosa* septicemia with multiple abscesses in the kidney, prostate and lung is included in our series.[36]

The severe form of viral hepatitis with intense jaundice seldom if ever shows variable and severe ocular manifestations and severe myalgia. It must be emphasized that pruritus is universally absent in leptospirosis.

The clinical recognition of the anicteric form of leptospirosis poses a serious problem to most physicians. Lethargy, headache, erythematous rashes, high fever, and bradycardia are common findings. The disease may be indistinguishable from typhus, typhoid fever, dengue fever, adenovirus infections, influenza, etc.

TABLE 4.
Analysis of Deaths (13 patients)

Age	Sex	Day of Disease & of Death	Coma	Oliguria	Hemorrhagic Tendency	W.B.C. (in 1,000)	Values at Death: Serum bilirubin (mg.)	Values at Death: Blood NPN (mg.)	Cause of Death	Complications
5	M	7	+	+	+	34	—	—	G.I. Hem.	—
52	M	7	+	+	+	37	8.6	52	G.I. Hem.	—
29	M	16	+	+	+	10.9	29.4	103	Renal	—
63	F	23	+	+	+	19.6	5.8	258	Renal	—
29	M	20	+	+	0	32	130*	270	Renal	Advanced pulm. tuberculosis
50	M	26	+	+	0	24	30.8	180	Renal	—
49	M	12	+	+	+	17	32	150	Renal	—
56	M	23	+	+	+	57	200 (Index)	240	Renal	B. Pyocyaneous Septicemia
52	F	11	+	+	+	47	124 (Index)	214	Renal	—
35	M	14	+	+	+	17	102 (Index)	240	Renal	—
43	M	8	+	+	0	—	—	—	Renal	—
63	F	21	+	+	+	20	5.6	210	Renal	—
46	M	12	+	+	+	17.5	150*	84	Renal	—

*Measured as Icteric Index

Trichinosis is accompanied by intense eosinophilia.

The differential diagnosis of acute leptospiral, from any other form of meningitis rests on the clinical approach and the efficacy of the laboratory efforts. A clinical differentiation between acute leptospiral encephalopathy and a cerebral abscess is at times impossible.

Treatment

There is no known effective specific antimicrobial agent for the leptospiral infections,[57] and the favorable response of the experimentally or spontaneously infected animal to various antibiotics does not apply to man,[58-62] except among the anicteric form of the disease observed by Gsell.[45] Erratic results have been obtained from the use of convalescent sera, and the infection is not responsive to arsenicals.[3] The latter drugs are contraindicated in view of the widespread renal, cerebral, cardiac and pulmonary pathology.[36, 57]

Awaiting further developments, the most acceptable management consists of maintenance of fluid and electrolyte balance; restriction of fluids to 800cc. of intravenous 5% glucose in water with addition of normal saline solution for the daily loss in vomitus, urine and feces. Excessive administration of fluids and the use of diuretics must be avoided. Normal serum potassium and other electrolyte levels should be carefully maintained. Parenteral insulin with glucose, potassium absorbing resins, enemata and the use of the artificial kidney may be life saving. It must be emphasized that electrolyte and fluid depletion may ensue during the recovery phase when daily diuresis may exceed three liters.

The issue of life or death may depend exclusively on the capacity for recovery of adequate function by the renal tubular cells. This is only achieved by a radical improvement in the hemodynamics, and the restoration of fluid and electrolyte balance. The mortality among the icteric patients ranges from 10 to 48% [2, 7, 36] Death during the first week of illness is caused by massive hemorrhage or a secondary bacterial infection. Peripheral vascular collapse, persistent oliguria, marked azotemia, coma and convulsions are the most ominous prognostic signs (Tables 4 and 5).

TABLE 5.
Associated Conditions and Complications

	Cases	Deaths
Cirrhosis of Liver	6	0
Pulmonary Tuberculosis	2	1
Retinal Hemorrhages	2	0
Peripheral Neuritis	1	0
Thrombophlebitis	1	0
Myringitis	1	0
B. Pyocyaneous Septicemia	1	1
Subacute Leptospiral Endocarditis	1	1

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NOTE: *Due to a lack of space, it was not possible to carry the author's carefully documented references. Therefore, the bibliography will be available on request from The Journal office.* Editor.

Fifteen-Year Follow-up Study of Patients with Myocardial Infarction

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Anticoagulants have obscured the natural history of myocardial infarction and clouded recent thinking. Three-hundred and ninety-four cases, treated before anticoagulants, and of whom 18.4% survived more than 15 years are presented.

DRUGS, particularly anticoagulants, operations on the coronary arteries, and diets containing unsaturated fats, are commonly recommended to individuals who have had a myocardial infarction, in an attempt to increase the life expectancy. Since it is suggested that such agents must be used for the entire life of the individual, long-term studies of those who did not have any special type of therapy, including antiacoagulants, are necessary to serve as controls for an evaluation of such agents and procedures.

Material

This report is such a control study. It is a 15-year follow-up of individuals who recovered from their first myocardial infarction and who lived more than two months. We have previously made five-year and ten-year follow-up studies of individuals who survived their first myocardial infarction for at least two months. The five-year follow-up study was based on 653 patients who were observed from January 1, 1940 to July 1, 1951 and followed until July 1, 1956.[10] The 10-year follow-up study was based on 211 patients who were observed from January 1, 1940 to July 1, 1945 and followed until July 1, 1955.[9] The same method of selection of cases was pursued as was described in the previous reports. Only those with characteristic clinical and electrocardiographic evidence and a precisely determinable onset of the infarction were selected. Patients are often seen, particularly those with slowly progressive coronary artery disease, who must have had a myocardial infarction but for whom the date of the infarction cannot be determined. These were excluded from the study. All patients were seen in private practice. None of the patients received anticoagulants during the first two months after the onset of the infarction nor have they received anticoagulants or other special therapy after the two-month survival period.

A total of 394 individuals met the above criteria. The onsets ranged from January 1, 1940 to January 1, 1948 and the patients were followed to January 1, 1963. Of these, 92% had adequate follow-up. A total of 364 cases were then available for analysis. There were 306 males (84%) and 58 females (16%).

TABLE 1
Course of 364 Cases as to 15-year Survival

Died Within 15 Years		Survived 15 Years	
No. of Cases	% Total	No. Cases	% Total
297	81.6	67	18.4

Table 1 shows the course of the 364 cases as to the 15-year survival period. A total of 67 (18.4%) lived 15 or more years. There are in the literature two other 15-year follow-up studies similar to this report. They are summarized in Table 2. Richards, Bland and White[7] reported that of 162 patients observed in the decade 1920-1930 who had survived their first attack of myocardial infarction for one month, 23 (14%) were alive after 15 years. Cole, Singian and Katz[4] reported that of 285 patients observed from 1932-1941 who had survived their first attack for two months, 10% survived for at least 15 years. There are other reports of 15-year follow-up studies after a myocardial infarction[3,8] but in these some patients were included who were not seen in their first attack or mention is not made as to the

TABLE 2
Summary of 15-year Survival Rates in Literature

Author	Immediate Survivol Time	No. of Coses	% Who Survived 15 yrs. or longer
Richards, Blond & White (7)	1 mo.	162	14
Cole, Singion & Kotz (4)	2 mos.	285	10
Weiss and Weiss	2 mos.	364	18

*Doctor Weiss, Senior, died suddenly February 25, 1963, during the completion of this manuscript. He was an assistant professor of medicine at the University of Louisville School of Medicine.

**Instructor in medicine at the University of Louisville School of Medicine.

TABLE 3
Distribution of Cases by Sex

Sex	% Who Died Within 15 yrs. No.	% of Total	% Who Survived 15 yrs. No.	% of Total
Male	250	81.7	56	18.3
Female	47	85.3	11	17.7
Total	297		67	

TABLE 4
Duration of Life of the 41 Patients Who Died within the 10-15 Year Period

Period (years)	Males	Females
10-11	7	3
11-12	5	2
12-13	9	1
13-14	6	0
14-15	7	1
Total	34	7
	(250)	(47)
% of Totals	14%	15%

number of patients who were taking anticoagulants after a one- or two-month recovery.

Table 3 shows the sex factor as to survival. The per cent of each sex who died within 15 years was approximately the same.

Table 4 is an analysis of duration of life of those who died during the tenth to fifteenth-year period of observation. There were 34 men and 7 women who died in this period. This represents 13.6% and 15% respectively of the 250 men and 47 women who died during the entire 15 years. Approximately the same number died each year during this tenth-fifteenth year period. Duration of life, by years, of those who died during the first five and ten years after survival was tabulated in our five[10] and ten-year[9] follow-up studies. Most patients who die, do so in the first five years after the two-month survival period established for these studies.

Table 5 is an analysis of the factors in mortality and the 15-year survival as to sex and age at the time of onset of the myocardial infarction. It is obvious that more young people will live more than 15 years after an infarction than those whose age at the time of the infarction was 60 years or beyond. Thus, of 15 men whose age at the time of the infarction was from 30-39 years of age, 7 (47%) survived at least 15 years whereas only 3 (11%) of 29 patients aged 70 or over survived more than 15 years. However, it becomes clear that when mortality ratios are used the life expectancy of younger patients is shortened.[2] There is no significant sex difference in mortality for the same age of onset. Cole, Singian, and Katz[4] noted that males had a slightly better prognosis than females. They attributed this to the fact that the males were younger than the females in their series of cases. Richards, Bland and White[7] found a decreasing survival rate in women as compared with men, particularly after the ten-year survival period.

Discussion

No attempt was made to make a statistical analysis as to 15-year survivals based on the functional status after the two-month survival of the initial myocardial infarction. Obviously, the patient who has made a good functional recovery will live longer than one who survives the initial impact disabled by congestive heart failure, angina pectoris, or a cerebral embolism. Elaborate hemodynamic studies to determine the integrity of the myocardium, or the coronary circulation, are not necessary.

TABLE 5
Age at Time of Onset with Relation To Sex Distribution and Survival

Age at Onset	No. Who Died within 15 yrs. Male	Female	No. Who Survived over 15 yrs. Male	Female	Total Male	Total Female
30-39	15	0	7	0	22	0
40-49	47	2	14	1	61	3
50-59	95	9	27	6	122	15
60-69	77	26	7	2	84	28
70-89	16	10	1	2	17	12
Total	250	47	56	11	306	58

TABLE 6
Summary of Five, Ten and Fifteen-year Survival Rates in the Literature

Author	Immediate Survival Time	No. of Cases	5-Year Survival %	10-year Survival %	15-year Survival %
Richards, Bland & White[7]	1 mo.	162	49	31	14
Cole, Singian & Katz[4]	2 mos.	285	67	44	10
Weiss and Weiss[11]	2 mos.	653	60	—	—
Weiss[9]	2 mos.	211	—	37	—
Weiss and Weiss	2 mos.	364	—	—	18

Symptoms are a valuable guide. All authors are agreed that the degree of functional recovery and the duration of such recovery are important factors in assessing the ultimate prognosis.

The number of patients who had diabetes was so few that any data relative to diabetes had no statistical significance. There are in the literature no 15-year survival studies of diabetic patients who had a myocardial infarction.

A statistical study of the effect of hypertension on the 15-year prognosis was not made. It is evident that an individual with a myocardial infarction complicated by hypertensive heart disease, will not live as long as one who does not have such a handicap.

We were unable to make a comparative study of the effect of social status on the fifteen-year prognosis. The majority of our patients were executives, "white collar" workers, or professional individuals. As an explanation for the report by Morris et al[6] on 123 doctors in England who had an 83 per cent five-year survival, McMichael and Parry[5] state that physicians can take better care of themselves and avoid undue physical strain. This certainly does not apply to physicians in this area.

Of the 56 men who were alive at the end of 15 years, 40% were still at their work or business. Some were able to follow modified work programs but all were not economically rehabilitated. Some of those who were not working were retired because of their age and did not have cardiac symptoms. As stated above, should symptoms of coronary or myocardial insufficiency manifest themselves after the survival period of the infarction, few individuals are alive 15 years later. The earlier the age of the onset of infarction, the more likely will an individual still be employable after fifteen years. In our five-year follow-up study of 431 men who returned to work after their first myocardial infarction, 67% were still employed.[11] It is expected that the work status of patients will alter as they become older, have another myocardial infarction, manifest angina pectoris, heart failure or develop a complicating disease such as hypertensive heart disease or calcification of the aortic valve. It is still noteworthy that 40% of the men were still working at the end of 15 years.

A detailed analysis of the cause of death was not attempted since this was done in our five[10] and ten-year[9] follow-up studies. Almost all deaths are due to cardiovascular diseases. This includes sudden or relatively sudden death, a new myocardial infarction, congestive heart failure and cerebrovascular accidents. The exact incidence of death from another myocardial infarction could not be determined, since many patients did not live long enough in their final illness to have an electrocardiographic examination. Achor et al[1], from an extensive autopsy experience, have documented the types of cardiac death which invariably result after the initial recovery from a myocardial infarction. These results confirm our observations.

Summary

A 15-year follow-up study was made of 394 individuals who lived more than two months after their first myocardial infarction.

None of the patients received anticoagulant therapy during the first two months after the onset of the infarction nor did they receive anticoagulants or other special therapy after the two-month survival period.

Of these, 18.4% lived more than 15 years.

The per cent of each sex that died within 15 years was approximately the same.

Most patients who die, do so in the first five years after the initial two-month survival period.

More young people live more than 15 years after an infarction than do those in the older age group.

The patient who has made a good functional recovery will live longer than the one who survives the initial impact complicated by congestive heart failure, hypertensive heart disease, angina pectoris, cerebral embolism, or a pulmonary embolism.

Of 56 men who were alive at the end of 15 years, 40% made a complete or partial economic recovery.

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SPECIAL ARTICLES

Blue Shield—1965 Variety†

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Ft. Lauderdale, Fla.

IN 1945, BLUE SHIELD began with an enrollment of about one and a half million people. Twenty years later, in 1965, Blue Shield Plans are providing an ever-growing degree of medical care protection for more than 53 million Americans.

When we compare the typical Blue Shield benefit pattern of 1945 to our 1965 benefit programs, it is clear that tremendous changes have taken place in the field of pre-paid health services during the past 20 years. The 1945 variety of Blue Shield primarily offered surgical coverage, whereas Blue Shield of 1965 almost universally covers, in addition to surgery, medical care in hospitals, both regular and intensive, obstetrics, consultation, and many other elements of a rounded medical program.

Blue Shield has developed along the same lines as other national organizations and institutions.

For example, within the General Motors organization, while the names and symbols of the company are known throughout the country, the products are tailored to some degree to local and regional needs. For instance, no car leaves the assembly line in Michigan without a heater; none leaves the assembly plant in Atlanta without an air-conditioner. Nevertheless, the profile of the Chevrolet is identical in every state, and its essential parts are available and interchangeable among all the areas of assembly.

This mixture of basic uniformity and local variation of our product is typical of Blue Shield. A common basic principle in the origin and development of each of our 75 Blue Shield Plans has been that of local responsibility for meeting local needs. This means that each plan has grown up in its own community and has shaped its program of benefits to meet the needs of its citizens, as interpreted by the local medical profession.

Local autonomy has paid off, too. It has attracted hundreds of physicians into the challenging job of directing plan policy; and it has given the entire Blue Shield movement the flexibility needed to weather depressions, inflations, war-time controls, and peace-time complacency. It has made possible a variety of experimentation, the results of which the Blue Shield plans have shared with one another.

But because of the nature of our product, there has been so wide a variation in the detail of our programs that Blue Shield, as a national entity, has had considerable difficulty in developing what might be called a national Blue Shield image. At the present time, one of our principal needs is to develop a product that is both universally obtainable and exchangable, and at the same time, adaptable to local circumstances and needs.

For nearly twenty years, we have been struggling in Blue Shield to create a national product, a program of medical benefits that we could present to the market in order to meet the growing demands of employers and labor organizations who are seeking similar benefits for their workers and members throughout the United States.

Our efforts to meet these rising demands have taken several channels. One approach was the development of the Blue Shield and Blue Cross insurance companies known as Medical Indemnity of America and Health Service, Inc. These twin corporations have been principally used to fill the gaps by supplementary underwritings wherever local plans cannot completely provide the program demanded for a national account. Another device has been the syndicate arrangement such as was developed for the steel industry. Under this arrangement, one of our local plans has served as the control plan and has supervised a benefit pattern offered through local plans serving the steel workers in various parts of the country. A third approach has been that devised for the Federal Employee Health Benefit program. In this instance, all Blue Shield plans have agreed to underwrite and administer a uniform national program of benefits—though in a few cases, for local reasons, the local plan's participation has been confined to servicing rather than doing a complete administrative job.

Each of these approaches to the problem of providing a national Blue Shield contract has been useful in its time. But we have yet to develop for ourselves a national program of benefits—which we can present to the market as a nationally available Blue Shield program, without prior negotiation and acceptance by the individual plans.

† Presented March 18, 1965 at the Interim Meeting of the Kentucky Medical Association. Edited version.

** Doctor Carson is chairman of the Board of Directors of the National Association of Blue Shield Plans.*

In our efforts to improve Blue Shield, the most important recent development is what we call the Prevailing Fee Program. Here the attempt is to provide a mechanism whereby Blue Shield would pay a physician the fee which he ordinarily charges his regular patients—in effect, the fee that is charged by 90% of physicians in a given community.

By reason of circumstance, custom, and local economy, it has been found that fees, in any specific area, are fairly well standardized. Our studies have shown that 90% of physicians in any given community charge approximately the same fee for the same service; and we have found less than 10% of physicians regularly charge their patients more than the usual fee charged by the majority of physicians in the community.

This minority whose charges are generally in excess of the average in the community are, as a rule, those whose patients are in a special income bracket. These patients in the higher income brackets usually do not constitute more than 10% of the total population in any community.

Our Prevailing Fee program would provide for payment in full of physicians charges by Blue Shield. The fee schedules would be established by individual physicians and the range of acceptable and payable fees would be established by the majority of the physicians in that community.

The Prevailing Fee program offers several advantages which we feel represent an advance over earlier methods. First, the majority of physicians would receive payment in full of their usual charges. Second, the patient would be protected by having his bill paid in full and he would therefore have the security of prior knowledge that his medical costs will be paid. Finally, the aggregate cost of medical care in the community would not be increased by the promulgation of a fee schedule which might represent either a higher or lower level of compensation for the local physicians than they had already established through their own practices.

In other words, under the Prevailing Fee program, Blue Shield would not either raise or ower the cost of medical care in the community, but the level of Blue Shield compensation to physicians would rise or fall in proportion to the changing economy of the area involved.

The National Association of Blue Shield Plans is now engaged in presenting this program to the medical profession and in making it available wherever the profession expresses an interest in accepting it. There is nothing compulsive or aggressive about our effort to make this program known to physicians. On the other hand, it is essential that the profession, through its medical associations, become well-informed as to the philosophy, the nature and the details of this program. It is equally essential that before adopting such a program, the profession satisfy itself that the advantages far outweigh any possible disadvantages. Properly and intelligently applied, we believe that the Prevailing Fee program will help to prevent the distortion of medical practice which is so often brought about when physicians have lost or abdicated control of their economic arrangements.

Time scarcely permits me to elaborate all the details of this idea, but with this introduction, it is hoped that the Medical Association of Kentucky will become sufficiently interested and informed to put this program into operation and make it work in your state.

The second major aspect of our 1965 Blue Shield picture is the new or at least expanded role which Blue Shield may have to play in the near future when the program now being put together by the Federal government goes into operation throughout the country.

Regardless of the manner and extent to which the new medical care legislation will cover the services of physicians, we know that care will be provided our senior citizens just as it always has in the past. It will still be the doctor who will admit the patient to the institution—of whatever type. It will still be the physician who will attend and treat the patient while he is there; who will discharge him to the next facility; who will be accountable for his hospital days; who will be responsible for his obtaining enough, too much, or too little laboratory work; who will be accountable for the drugs ordered and prescribed; and, in the long run, for the cost of his care.

The basic purposes that are inherent in the national legislation which is now almost certain to be adopted by Congress cannot fail to involve us practicing physicians in publically directed and supported medical practice. Indeed the deliberations of the House of Representatives Ways and Means Committee during the past two weeks clearly show that there is a strong bipartisan consensus on several points of major importance. First, Federally subsidized or supported programs of medical care for the aged cannot be confined to basic hospital and nursing home care; second, unless the voluntary health insurance mechanisms in this country—most notably, Blue Cross and Blue Shield—can be encouraged and assisted in supplementing this basic Federal program, there may be no practical way of confining and containing the expansion of the Federal program itself. Third, there is not the slightest doubt that the policy-makers for the Federal government, both in Congress and H.E.W., recognize that in Blue Cross and Blue Shield, we now have a mature and competent instrument capable of playing a major part—on behalf of the voluntary hospital system and the free and independent medical profession—in solving the medical care problems of the aged—or for that matter, of any other identifiable group of citizens.

Blue Shield is all that stands between us as individual physicians and the vast, unlimitable power of the Federal government. We know that it is the wish and intent of the Federal government to deal with us as physicians only through the medium of our own chosen pre-payment instruments, Blue Cross and Blue Shield, and—to whatever extent may be practical and necessary—through the commercial insurance companies. But it must be clear to us that if we are to have any voice in shaping the medical care program of the immediate future, and in controlling its administration, it will be through Blue Shield.

Never before in the quarter century in which medi-

(Continued on Page 1044)



For These Things—We Are Grateful

WHILE THE American physician today faces a number of very grave issues, he does, at the same time, have much to be thankful for. We are now between two of our most-loved holidays, Thanksgiving and Christmas, which emphasize and bring into sharp focus that we should never become so busy that we are not grateful for or forget the source of our many blessings.

Your editors and staff of The Journal of KMA have much for which to be thankful. The road we have traveled this year has not been without its rough places—some of them financial. By and large it has been a good year.

We are grateful that the quality of the scientific content of our Journal continues to improve. We are very thankful to those who have made these contributions. We express our gratitude to the many people who have contributed regularly to the several departments of our publication. We appreciate the efforts of those who have gone to the trouble of telling us what they thought was wrong with our Journal and to those who have given us a pat on the back.

We are so very appreciative of the advertisers who patronized our book during 1965. We take pride in the fact that we have a growing number of them. Not only do our advertisers serve us by buying space in our columns, but also by acquainting us with the products we must use.

We would not forget our State Medical Journal Advertising Bureau, which obtains, handles insertion orders, and collects for the space we have to offer. The Bureau renders a valuable service. To our printers, Gibbs-Inman, and their fine staff, who are so cooperative, we say another big "thank you".

Most of all we are grateful for the opportunity to live in a country like America, where we can say what we think, and where we can worship God as we choose. Our prayer for the future is that we as physicians, joining with other good Americans, might always have the will and desire to fight to preserve our country and our freedom.

THE EDITORS

The Volunteer

THE YEAR 1965 has been a particularly eventful one for the medical profession. Aside from the many noteworthy scientific advances during the year, there has been much ferment and activity regarding the relationship of medical care to our society in general. Organized medicine was still adjusting to the passage of Medicare (PL 89-97) by Congress when an even greater social bomb was dropped in the form of the report of the President's Commission on Heart Disease, Cancer and Stroke.

The program as recommended by the Commission was quickly introduced into Congress and hurried on its way to passage. If the program had passed in its original form it would have radically changed the patterns of medical practice in this country within a brief period of time. The program of the Commission did eventually pass the Congress but in

greatly modified form, and one more acceptable to most physicians. Credit is due to the leaders of the American Heart Association, American Cancer Society and other medical groups for their part in a determined effort to keep a hastily contrived piece of health legislation from becoming law. In retrospect, it is a curious thing that the President's Commission on Heart Disease, Cancer and Stroke did not consult the American Heart Association or the American Cancer Society in the delopment of the Commission's recommendations.

With the entrance by the Federal government into the field of cardiovascular disease and cancer on such a massive scale, it was stated by some physicians and others alike that there would be no further need for such volunteer organizations as the Heart Association and the Cancer Society. It was the opinion of some that the huge amounts of Federal money being spent would make the efforts of the volunteer groups seem hardly worth the time and effort. Others doubted that the average citizen in our society would make voluntary contributions when large tax funds were being used for the same purpose.

There are reasons to believe that the volunteer health groups should become stronger at this point in our society's development rather than folding up and defaulting all to a government agency. It is desirable to have volunteer, non-government, informed and experienced groups observe and constructively criticize the programs and the spending of Federal health agencies. It is also conceivable that in some instances the programs by a volunteer group might be more inventive and flexible than comparable ones establishd by the government.

The volunteer health groups permit millions of our citizens to participate in a work that is meaningful to them as individuals as well as an outlet for creative interests and energies.

Experienced travelers abroad, particularly to the countries behind the Iron Curtain, have commented on the lack of volunteer groups to be found in these countries. One reason given for their absence is that the governments of these countries will not permit criticism of the government in power. It must seem strange to an American not to have volunteer groups around. The average American often gives a part of his spare time as a volunteer in some kind of worthwhile work in his community. The volunteer adds to our American society a special, important, unique and highly activated ingredient that is not to be underestimated.

WALTER S. COE, M.D.

We Wish You
A Very Pleasant Holiday Season

Sam A. Overstreet, M.D., Editor
and
The Journal Staff

*Crossing the Bar**

Alfred, Lord Tennyson

Sunset and evening star,
And one clear call for me
And may there be no moaning of the bar,
When I put out to sea,

But such a tide as moving seems asleep,
Too full for sound and foam,
When that which drew from out the boundless deep
Turns again home.

Twilight and evening bell,
And after that the dark!
And may there be no sadness of farewell,
When I embark;

For tho' from out our bourne of Time and Place
The flood may bear me far,
I hope to see my Pilot face to face
When I have crossed the bar.

**This tribute is printed in memory of the 64 Kentucky physicians who passed away during the past year. See following page for complete list.*

Deceased Kentucky Physicians

1965*

A. Glenn Barton, M.D., Louisville
Henry D. Berryman, M.D., Louisville
Henry C. Blount, M.D., Cynthiana
Edward Boss, M.D., Louisville
Samuel M. Bowman, M.D., Summershade
Philip D. Briggs, M.D., Louisville
Adolphus D. Butterworth, M.D., Murray
Leonard Campion, M.D., Lola
William P. Cawood, M.D., Harlan
Chester B. Creech, M.D., Middleburg
Gilbert A. Cook, M.D., North Middletown
William E. Dean, M.D., Covington
Cander G. Depp, M.D., Hiseville
Katherine Dodd, M.D., Atlanta, Ga.**
Relda E. Elliott, M.D., Marion
Helen B. Fraser, M.D., Frankfort
William B. Foreman, M.D., Louisville
James W. T. Fuller, M.D., Mayfield
C. B. Gettelfinger, M.D., Louisville
Arthur L. Goodman, M.D., Louisville
William C. Gose, M.D., Pikeville
Gerald Greenfield, M.D., Louisville
Robert W. Hahs, M.D., Murray
Joseph B. Helm, M.D., Smith's Grove
Robert D. Higgins, M.D., Ashland
William J. Hockaday, M.D., Louisville
William P. Humphrey, M.D., Sturgis
W. T. Jessee, M.D., Plummer's Landing
Marshall M. Jones, M.D., Lexington
Charles W. Justice, Sr., M.D., Ludlow
Preston O. Lewis, M.D., Evarts
Ellen Lichtenstein, M.D., Hopkinsville
Samuel C. Long, M.D., Monterey
Joshua B. Lukins, M.D., Louisville
Shelton H. Mann, M.D., Louisville
Harry E. McCord, M.D., Ludlow
John W. McGowan, M.D., Lexington
Carlisle Morse, M.D., Louisville
Robert C. Moss, M.D., Bowling Green
A. L. Parsons, M.D., Louisville
Minor B. Payne, M.D., Hazard
Thomas A. Pease, M.D., Cunningham
Marvin C. Pentz, M.D., Nicholasville
Virgil L. Powell, M.D., Paducah
George Purdy, M.D, New Liberty
Fred W. Ray, M.D., Independence
William D. Reddish, M.D., Lexington
G. H. Ross, M.D., Stamping Ground
G. B. Schroering, Jr., M.D., Hopkinsville
Jamie P. Scott, M.D., Ashland
Horace H. Seay, M.D., Louisville
Wade Schacklett, M.D., Louisville
A. B. Shelton, M.D., Manchester
W. W. Shepherd, M.D., Campbellsville
Charles P. Shields, M.D., Paducah
Walter L. Sims, M.D., Bowling Green
James A. Stumbo, M.D., Martin
James B. Tarter, M.D., Russell Springs
C. A. Thompson, M.D., South Shore
E. M. Thompson, M.D., Frankfort
David S. Traub, M.D., Louisville
Brent Weddle, M.D., Somerset
Waldo R. Williams, M.D., Louisville
Karl D. Winter, M.D., Louisville

** List of names of deceased physicians available to The Journal as of November 20, 1965.*

***Former faculty member, University of Louisville School of Medicine.*

The Pinckney Thompson Memorial Meeting of The Kentucky Medical Association

Terrace Room, Kentucky Hotel, Louisville, Kentucky, September 20-23, 1965

Digest* of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

Garnett J. Sweeney, M.D., Liberty

Speaker of the House, Presiding

First Session

Doctor Sweeney called the meeting to order and asked Gabe A. Payne, Jr., M.D., Hopkinsville, to give the invocation. John A. Logan, M.D., Webster County, chairman of the Credentials Committee, reported that a quorum was present. There was a motion and second to accept the minutes of the 1964 session of the House of Delegates as published in the December 1964 issue of The Journal of KMA. The motion carried.

Henry B. Asman, M.D., KMA secretary, presented the general announcements. The secretary reported that the President's Luncheon speaker would be Dr. Philip M. Crane of Bradley University. Doctor Asman stated that the seven reference committees would convene for their session at 2:00 p.m., Monday, on the mezzanine floor of the Kentucky Hotel. The opening scientific session was to begin on Tuesday, September 21, at 8:50 a.m., in the Convention Center.

The secretary read the list of physicians who had died since the 1964 meeting and the House stood for a moment in silence in their memory. The names of the physicians, their locations and dates of death are as follows:

Barton, A. Glenn, (Member), Louisville, Sept. 27, 1964
Berryman, Henry D., Louisville, July 7, 1965
Blount, Henry C., Cynthiana, Dec. 2, 1964
Boss, Edward, Louisville, Aug. 5, 1965
Bowman, Samuel M., Summershade, March 19, 1965
Briggs, Phillip D., (Member), Louisville, Jan. 13, 1965
Butterworth, Adolphus D., (Member), Murray, Jan. 2, 1965
Cawood, William P., Harlan, Oct. 15, 1964
Cook, Gilbert A., North Middletown, Oct. 10, 1964
Dean, William E., Covington, Apr. 19, 1965
Elliott, Relda E., (Member), Marion, March 14, 1965
Fraser, Helen B., (Member), Frankfort, July 16, 1965
Fuller James W. T., (Member), Mayfield, Oct. 29, 1964
Gettelfinger, Clement B., Louisville, Aug. 26, 1965
Gose, William C., (Member), Pikeville, March 17, 1965
Greenfield, Gerald, (Member), Louisville, Jan. 13, 1965
Hahs, Robert W., Murray, Jan. 28, 1965
Helm, Joseph B., Smiths Grove, Feb. 27, 1965
Higgins, Robt. D., Ashland (In Raleigh, NC), Oct. 8, 1964
Humphrey, William P., (Emeritus), Sturgis, Oct. 10, 1964
Jessee, W. T., Plummers Landing, Sept. 1964
Jones, Marshall M., Lexington, Oct. 6, 1964
Lichtenstein, Ellen, Hopkinsville, Dec. 6, 1964
Long, Samuel C., Monterey, June 20, 1965
Lukins, Joshua B., (Emeritus), Louisville, March 24, 1965
Mann, Shelton H., (Member), Louisville, March 30, 1965
Moss, Robert C., Bowling Green, Feb. 11, 1965
Parsons, A. L., Louisville, Sept. 1964
Payne, Minor B., Hazard, Aug. 8, 1965
Pease, Thomas A., Cunningham, (In California), Nov. 1, 1964
Pentz, Marvin C., Nicholasville, Apr. 28, 1965
Powell, Virgil L., (Member), Paducah, Nov. 4, 1964
Purdy, George, New Liberty, Oct. 16, 1964
Ross, G. H., Stamping Ground, Dec. 4, 1964
Schroering, Gerald B. Jr., Hopkinsville, Apr. 10, 1965
Seay, Horace H., (Member), Louisville, June 21, 1965
Shelton, A. B., Manchester, Apr. 7, 1965
Shepherd, Wm. W. Jr., Campbellsville, May 16, 1965
Shields, Charles P., Paducah, July 11, 1965
Sims, Walter L., Bowling Green, March 10, 1965
Stumbo, James A., Martin, March 3, 1965
Tarter, James B., Russell Springs, May 4, 1965
Thompson, Christopher A., South Shore, May 2, 1965
Thompson, Edward M., (Member), Frankfort, June 20, 1965
Traub, David S., (Member), Louisville, June 14, 1965
Weddle, Brent, (Member), Somerset, March 27, 1965
Williams, Waldo R., (Member), Louisville, May 26, 1965
Winter, Karl D., (Emeritus), Louisville, (In Mississippi), Dec. 21, 1964

Editorial Note: A tape recording was made of the two sessions of the House of Delegates, and any member who desires to examine the transcript of the proceedings, may come to the headquarters office and listen to the recording.

The speaker announced the reference committee appointments as follows:

Reference Committee No. 1—Reports of Officers and Board of Trustees

Robert T. Longshore, M.D., Covington, Chairman
Carl Brueggemann, M.D., Covington
Thomson R. Bryant, Jr., M.D., Lexington
Mary Pauline Fox, M.D., Hazard
Joseph H. Kurre, M.D., Owensboro

Reference Committee No. 2—Scientific Assembly and Medical Education

E. C. Seeley, M.D., London, Chairman
Eugene H. Conner, M.D., Louisville
W. B. Haley, M.D., Paducah
Paul J. Parks, M.D., Bowling Green
J. Sankey Williams, M.D., Nicholasville

Reference Committee No. 3—Legislative Activities

Richard F. Greathouse, M.D., Louisville, Chairman
J. S. Oldham, M.D., Owensboro
David B. Stevens, M.D., Lexington
J. R. Stevie, M.D., Covington
Ralph G. Thomas, M.D., Leitchfield

Reference Committee No. 4—Public Service and Allied Professions

Andrew M. Moore, M.D., Lexington, Chairman
William E. Becknell, M.D., Manchester
Philip D. Hitchcock, M.D., Edmonton
Walter I. Hume, Jr., M.D., Louisville
Dwight L. Blackburn, M.D., Berea

Reference Committee No. 5—Medical Service

Louis M. Foltz, M.D., Louisville, Chairman
W. Vinson Pierce, M.D., Covington
James L. Ferrell, M.D., Paris
David A. Hull, M.D., Lexington
J. E. Stephenson, M.D., Ashland

Reference Commitee No. 6—Constitution and Bylaws; Special Committees

Douglas H. Jenkins, M.D., Richmond, Chairman
Leroy C. Hess, M.D., Florence
Irving Kanner, M.D., Lexington
Joseph R. Miller, M.D., Benton
Henry W. Post, M.D., Louisville

Reference Committee No. 7—Miscellaneous

Sam Weakley, M.D., Louisville, Chairman
Tom Heavern, M.D., Ft. Thomas
C. C. Lowry, M.D., Murray
M. J. Evans, M.D., Middlesboro
Robert J. Salisbury, M.D., Mt. Sterling

The speaker stated the tellers for the meeting would be Carl Brueggemann, M.D., Covington; H. L. Bushey, M.D., Barbourville; and Martin Wilson, M.D., Bowling Green. Doctor Sweeney also stated that the KMA Delegates and Alternate Delegates to the AMA had been assigned to reference committees and would be serving as resource people during the committee hearings.

The reports of the officers and committees were presented at this time and referred to the respective reference committees by the speaker as follows:

Report of the President—Reference Committee No. 1

Report of the President, Woman's Auxiliary to KMA—Reference Committee No. 1

Report of President-Elect—Reference Committee No. 1

Report of Speaker of House—Reference Committee No. 1

Report of Chairman, Board of Trustees—Reference Committee No. 1

The speaker then recognized William Bizot, M.D., the chairman of the Awards Committee, for his nominations for the Distinguished Service Medal, and the Outstanding General Practitioner Award. J. Duffy Hancock, M.D., Louisville, was nominated for the Distinguished Service Medal. A motion was made, seconded and carried that Doctor Hancock be the recipient of this award.

The name of W. Gerald Edds, M.D., Calhoun, was placed in nomination for the Outstanding General Practitioner Award. The motion was seconded and carried.

At this time the House recessed for a coffee break provided by the Kentucky State Association of Medical Assistants.

After reconvening the House, Doctor Sweeney continued with the assignment of the reports to the various reference committees as follows:

Report of the Secretary—Reference Committee No. 1

Report of the Editor—Reference Committee No. 1

Report of the Treasurer—Reference Committee No. 1

Report of the Delegates to AMA—Reference Committee No. 1

Report of Executive Secretary—Reference Committee No. 1

Report of the Council on Scientific Assembly—Reference Committee No. 2

Report of the Council on Medical Education and Hospitals—Reference Committee No. 2

Report of Council on Legislative Activities—Reference Committee No. 3

Report of the Council on Medical Services—Reference Committee No. 5 with the following exceptions:
page 2, first full paragraph starting with "Members of the Council" and the last full paragraph at the bottom of the page starting with "The AMA has adopted a policy" will go to Reference Committee No. 2
page 4, numbered paragraph 2 referred to Reference Committee No. 3
page 5, numbered paragraph 4 at the top of the page, referred to Reference Committee No. 3
page 12, first full paragraph starting with "There was some discussion" referred to Reference Committee No. 4

Report of the Council on Communications and Public Service—Reference Committee No. 4 with the following exceptions:
page 15, second and third paragraphs relating to guest speakers' honoraria will go to Reference Committee No. 1
page 17, item 7 at the top of the page relating to the Good Samaritan Law plus the Board of Trustees recommendation on this item will be referred to Reference Committee No. 3

Report of the Council on Allied Professions and Related Groups—Reference Committee No. 4 with the following exceptions:
page 13, Roman Numeral paragraph 4 will go to Reference Committee No. 3
page 14, Roman Numeral paragraph 6 will go to Reference Committee No. 1
page 23, numbered item 2 referred to Reference Committee No. 3
First addendum to the Report entitled "Statement of W. K .Massie, M.D." referred to Reference Committee No. 3

Report of the Advisory Committee to the Editor—Reference Committee No. 6

Report of the Judicial Council—Reference Committee No. 6

Report of the Committee on Third Party Medicine—Reference Committee No. 6

Report of the Committee to Study the Constitution

and Bylaws—Reference Committee No. 6

Report of the Interim Meeting Program Committee —Reference Committee No. 6

Report of the Insurance Review Board—Reference Committee No. 6

Report of the Directors, Kentucky Physicians Mutual, Inc.—Reference Committee No. 5

Report of Board of Trustees, Rural Kentucky Medical Scholarship Fund—Reference Committee No. 5

Report of the McDowell Home Committee—Reference Committee No. 7

Report of the Memorials Commission—Reference Committee No. 7

Report of the Technical Advisory Committee on Indigent Medical Care—Reference Committee No. 5

Report of KMA Representative to Conference of Presidents and Other Officers of State Medical Associations—Reference Committee No. 7

Report of KMA Representative, U. of K. Chapter Student AMA—Reference Committee No. 7

Report of KMA Representative, U. of L. Chapter Student AMA—Reference Committee No. 7

Report of Advisory Committee to Selective Service —Reference Committee No. 5

Report of KMA Representative, Kentucky Mental Health Planning Commission—Reference Committee No. 5

New Business

The new business was then presented to the House and referred to the reference committees by the Speaker as follows:

(A) Resolution of Fayette County Medical Society on the subject of Administrative Relationship Between Hospitals and Private Practitioners of Medicine Practicing Within Hospitals—Reference Committee No. 5

(B) Resolution of Garrard County Medical Society relating to Prescription Procedures—Reference Committee No. 5

(C) Resolution of Jessamine County Medical Society on Commendation of University of Kentucky Medical Center—Reference Committee No. 2

(D) Resolution of Daviess County Medical Society relating to Oath Not to Discriminate—Reference Committee No. 3

(E) Resolution of Fayette County Medical Society on subject of State Bond Issue—Reference Committee No. 3

(F) Resolution of Todd County Medical Society relating to Legal and Ethical Implications of Participation and Non-Participation in Public Law 8997—Reference Committee No. 3

(G) Resolution of J. E. Stephenson, M.D., Delegate, Boyd County Medical Society, relating to Guidelines for Planning Community Medical Services—Reference Committee No. 5

(H) Resolution of Jefferson County Medical Society relating to Resolution from the Council on Legislative Activities as Submitted to the House in Report No. 13—Reference Committee No. 3

(I) Resolution of Trimble County Delegation on subject of Formal Compliance to Title VI of the Civil Rights Act of 1964—Reference Committee No. 3

(J) Resolution of Hollis Johnson, M.D., Jefferson County, relating to Voluntary State-Wide Testing for early Detection of PKU—Reference Committee No. 4

(K) Resolution of Rowan County Medical Society on subject of Private Use of Medical Students as Physicians for Hospital Profit—Reference Committee No. 5

(L) Resolution of Pulaski County Medical Society relating to Socialized Medicine—Reference Committee No. 3

The meeting places for the Nominating Committee for general officers and the six trustee districts were announced by the Executive Secretary. He stated that the Nominating Committee would report immediately at the close of the first scientific session on Tuesday morning at the Convention Center, and these nominations would again be read at the second meeting of the House on Wednesday, when according to the Bylaws, additional nominations could be made from the floor without discussion or comment.

With there being no further business, the meeting adjourned at 12:00 Noon.

Second Session

The second session of the House of Delegates was called to order on September 22, 1965, by the speaker. Carl Fortune, M.D., Lexington, gave the invocation. The chairman of the Credentials Committee, John Logan, M.D., reported that a quorum was present.

The speaker recognized the chairman of the Board of Trustees, Robert E. Pennington, M.D., who presented the final report of the Board of Trustees as follows: (The Board of Trustees passed the resolution at its September 22 meeting)

"WHEREAS, the 1965 Annual Meeting of the Kentucky Medical Association has been quite well attended and that an excellent scientific program has been presented, and

"WHEREAS, the House of Delegates wishes to express its appreciation to the Council on Scientific Assembly, our guest speakers, the 16 cooperating specialty groups and the 22 scientific exhibitors, and

"WHEREAS, 75 technical exhibitors have patronized our meeting and have added color and depth to it, and

"WHEREAS, the Smith Kline and French Laboratories has presented us with a most worthwhile 'party line telephone conference' and,

"WHEREAS, the Kentucky Hotel, the New Convention Center, the various forms of media along with all other organizations, agencies and individuals have cooperated in making this meeting successful.

"THEREFORE BE IT RESOLVED, that this House of Delegates express its lasting appreciation to all individuals and organizations that had any part in developing and presenting the 1965 Annual Session." Doctor Pennington moved the adoption of the resolution. The motion was seconded and carried.

Doctor Asman presented the announcements. He recognized the following representatives of state medical societies: Caesar Portes, M.D., president-elect of Illinois State Medical Society; Kenneth O. Neumann, M.D., president-elect of Indiana State Medical Association; Charles Sherwin, M.D., first vice-president of Missouri Medical Association; and Seigle W. Parks, M.D., president of the West Virginia State Medical Association.

The reports of the Reference Committees were then presented.

REFERENCE COMMITTEE NO. 1†

Robert T. Longshore, M.D., Chairman

Reports of Officers and Board of Trustees

Reference Committee No. 1 considered the following reports:

1. Report of the President
2. Report of President, Woman's Auxiliary to KMA
3. Report of President-Elect
4. Report of Speaker of the House of Delegates
5. Report of Chairman of Board of Trustees
6. Report of the Secretary
7. Report of the Editor
8. Report of the Treasurer
9. Report of the AMA Delegates
10. Report of Executive Secretary
15. Report of the Council on Communications and Public Service, page 15, second and third paragraphs
16. Report of the Council on Allied Professions and Related Groups, page 14, paragraph VI

Report of the President

The first thing I wish to do in this report is to thank all committees, officers and everyone who has taken part in making this past year a successful one for the Kentucky Medical Association. I especially wish to thank and to praise our Headquarters staff for their untiring and loyal efforts.

Without prolonging this report with trivia of routine, I would like permission to pass on to more important items that are pressing. Sufficient consideration, resolute and prompt actions will be necessary on all of the topics I propose to mention if the practice of medicine is to remain as a free, private competitive enterprise.

REDEDICATION: Each physician should review the Oath of Hippocrates and the Code of Medical Ethics of the American Medical Association. He should be fully informed of the true status of our present position and review all the factors that have placed us there. He should know that socialized medicine is the Socialist's dream and as said by Lenin "The keystone in the arch of the socialist state." After he studies these and all other related things and takes full inventory of himself, he should decide whether or not he is obligated to abide by the Code of Ethics that has made American medicine great. He should decide whether or not to do his part in preserving his profession as it has been preserved for him. In making this decision, he must be sure that he is on firm ground and that his sincerity cannot be questioned. He must rededicate himself to the true principles of the profession and hold firm to his convictions. Once this is done, our problems would be made less difficult. I ask that this suggestion be endorsed by the House.

COMMUNICATIONS BETWEEN NATIONAL, STATE AND COUNTY MEDICAL SOCIETIES break down somewhere along the line. The societies are not fully to blame for these failures. Some of the blame is at the grass roots itself. For example, many never attend the meetings of their own society, their district, state or national meetings. Many never read the Journal, the Communicator, the Secretary's Letter or the "Message from the President." The people who hear this report are not the ones that need to hear it. Perhaps a message sifts through now and then. We cannot quit. We must be informed ourselves and we must inform the others. My experience as president has led me to believe that we are not making satisfactory progress in setting up adequate communications between the county medical society, the KMA and the AMA.

The members of the county medical society should know the services that are available to them from the state association. The state should be given an opportunity to explain its many services. The same is true for the AMA. Now this cannot be accomplished unless there is proper interchange of information.

So, I would repeat a previously stated recommendation and urge each county society to plan at least one program a year utilizing one of the three sources of information, or any combination of them. They are your KMA delegates to the AMA, your State Association officers, or the members of your Headquarters staff.

I would further recommend that if this suggestion is adopted that the Board of Trustees give appropriate publicity to this action, following the 1965 Annual Meeting.

It is up to the local county medical society to initiate the idea. No one will write and ask for the privilege of speaking to you, but if you give your Association an opportunity to work with you and for you, we believe you will feel well repaid for your time.

PREPAYMENT HEALTH AND HOSPITAL PLANS have made great strides in the last 20 years. Blue Cross and Blue Shield alone have prevented the advent of nationalized medicine up to the present time. They have also forced commercial companies to improve their contracts. Blue Cross and Blue Shield are our own "babies," particularly Blue Shield. All Kentucky physicians are urged to study and compare our own Blue Shield program with other prepayment plans. Blue Shield is the conscience of the surgical-medical prepayment industry. Let all of us learn the difference between prepayment and insurance programs, and make judgements and statements based on facts, not emotions, half-truths and rumors.

I very much urge all to learn to read contract language and find out for yourselves what Blue Shield has done and is doing.

If we find abuse in any area of voluntary prepayment, let us have the courage to stop such unethical, thoughtless practices and prevent further encroachment of government regulatory bodies, with the attendant loss of freedom.

Let us resolve to make voluntary prepayment work even better for the people of Kentucky and help all prepayment organizations measure up to the high standards of our own Kentucky Blue Shield Plan.

The KMA has a special committee to assist in making prepayment plans work. I recommend that this Committee become more active, especially in the field of over-utilization, as well as other irregularities that imperil prepayment plans.

POLITICAL ACTION, distasteful as it is to physicians, is necessary. We must elect people to Congress who are favorable to our cause. Our program in Kentucky, carried out by KEMPAC, has done exceedingly well. If other states had done as well as Kentucky, we would be in much better position. We must keep up this program and institute other means also

†*In order to make the Digest of Proceedings of the second meeting of the House of Delegates more understandable and because it will occupy less space in The Journal, the KMA Board of Trustees passed the following motion "That if no dissenting action on the committee's recommendations is made either by the Council under which the committee serves or the KMA Board of Trustees, only the reference committee action on the report be printed in The Journal."*

if medicine is to remain a free competitive enterprise. The time has come for 100% united effort with all the courage that can be mustered. Sir Winston Churchill once said, "Success is never final and failure is never fatal. It is courage that counts."

Every practicing physician in the Nation should participate in the Political Action movements, because every physician's freedom is at stake. Some states are billing the physicians for the PAC dues along with the AMA, State and County Society dues. This is everyone's fight and everyone should contribute to it with his cash and his efforts. I hope the reference committee goes along with me in asking the House to approve the billing of KEMPAC dues along with the other dues. In making this recommendation, I do not imply that other efforts will not be necessary. KEMPAC dues cannot guarantee anything. Political action, plus other positive ethical, legal and moral action by 100% of the physicians of this country can.

1. Therefore, I recommend universal county billing along with the county society dues on a voluntary basis to all doctors.
2. I further recommend that at the time of our trustee district meeting in 1965-1966, KEMPAC be given a part on all district programs to present pertinent political information.
3. I recommend finally that all doctors and their wives start now to become politically and legislatively fully informed so that each in his own individual way can exert a positive and aggressive political action.

REGIONAL HOSPITAL PLANNING sounds humane, sensible, serviceable and desirable, but do not be misled by its sound of benevolence. This is part of the means of carrying out the original plan to completely socialize all medical care. First it will divide the profession by selecting groups to operate the centers. Both the hospitals and their staffs will be subsidized by local, state and federal tax funds to practice a monopolistic type of medicine. After the opposition is destroyed, the favored few perhaps would be placed on salaries which is the socialist plan for all physicians from the beginning. There probably isn't much this or any other organization can do, but we should know what is going on and do all we can.

PUBLIC LAW 89-97: By a stroke of the pen July 30, 1965, at Independence, Missouri, during an emotion packed ceremony, Public Law 89-97 went on the books and the fundamentals of American medicine and free enterprise went down the drain. This was the climax of a 30-year effort of the Communists, Socialists, labor unions, politicians, "do-gooders" and the parasites to break down the resistance of the bulwark of free enterprise in this country, the American physician. It was enacted against the advice of organized medicine who has spelled out the dangers and evils for 30 years. Ignorance, jealousy, hatred, and revenge were big factors among both the public and the Congress. The power seeking politicians could not resist the opportunity to take the political advantage of getting themselves elected, by selling out the American people, the medical profession, and their own souls, by committing this terrible crime against the people and widening the breach for total socialism and eventual communism.

The only thing compulsory about the law, so far as the physicians are concerned, is the payment of the taxes, at the same rate as the other self-employed people. There is nothing in it that compels him to cooperate in the setting up of the regulations, or the participation in the program. This was admitted by Mr. Cohen in an interview on August 6 and is said to be true by our own legal counsel. If there is any physician who harbors the illusion that he can work with Federal officials to implement Public Law 89-97, there must be a defect in his powers of observation and deduction. Mr. Cohen would not consult the recognized representatives of our profession before the bill became law, but now he appeals to them for help in implementing it and by persuading the nation's physicians to abandon the Oath of Hippocrates, the Code of Medical Ethics and bend to the Federal yoke, thus destroying the world's best medical care and blending the profession into the Great Society, which is another name for the socialist state.

The future of medicine lies before us, to shape as we desire. We may go forward as free practitioners, or we can take on labor's chains, forged by Abe Fortas, Arthur Goldberg, Wilbur Cohen, and Isadore Falk. The decision is ours, and ours alone.

I will not present a resolution because this is a question that must be settled by each individual, but I would hope that every physician in this country would be resolute in his determination to preserve the freedom of his profession by using every ethical, moral and legal means at his disposal. I ask this House of Delegates to join me in this desire.

Delmas M. Clardy, M. D., President
Kentucky Medical Association

Recommendations, Reference Committee No. 1

Reference Committee #1 approved the report of Doctor Clardy and makes note of the possibility of a misquote as attributed to Lenin, which may be in error.

We thank Doctor Clardy for his work during the year and agree that every physician in this country should be resolute in his determination to preserve the freedom of his profession by using every ethical, moral and legal means at his disposal.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of President Woman's Auxiliary to KMA

Woman Power—John Mason Brown says: "Charm is a glow within a woman that casts a most becoming light on others."—this is used in the auxiliary aim of promoting friendly relations for mutual understanding among physicians' families—Yes, and his community image, too. But Woman Power can have another force —when utilized, gentlemen, like that of triggering atomic energy.

Times change, demands change and the leader must be flexible. The state auxiliary, as well as every county auxiliary, has your approval and has medical society advisors. Unless auxiliary members know what their medical advisors want them to, and *not* do, they are not in a position to make an atomic energy contribution to your entire program. We *want* to be your right arm.

Please, read the March-April Issue of PR Doctor, pages 6-7 primarily. As the auxiliary president, may I ask you to be frank with us—guide us—and let us use our atomic energies to work with and for you.

You're the trigger to set it off.

The auxiliary has spread the light of learning through evaluation and education; and reflected it through live example and working meetings this year. *Read* our report and decide if your auxiliary is working on projects that you endorse.

I was proud of Kentucky at our National Auxiliary meeting in New York and the praise we received from many national chairmen in their reporting. Even to the executive secretary when she mentioned our cooperation with our state medical association and our governor on our Rural Health Program of "Immunization." The Diabetic and Education Week and legislation were others.

Legislative-wise our work will never be through for like medicine it is like a love affair, never smooth and never finished. We'll have Dr. Hoyt D. Gardner, of the AMPAC Board to give us a ten minute presentation on KEMPAC in tomorrow's auxiliary conven-

tion general session. The state auxiliary legislation chairman will have mimeographed for everyone the latest list of bills being drafted and those that are already drafted in regard to health for presentation to the Kentucky Legislature when it convenes. Thus we can be alert and decide where to best direct our strength.

The presidents of six allied health organizations have been invited to attend Tuesday's luncheon and the afternoon general session of convention to hear what our county auxiliaries have to report. Yes, we're trying to be live examples with working meetings to carry medicine's picture to all organizations which look to the advancement of health and health education.

Recommendations: (and these are mine)
1. May the state auxiliary president and president-elect receive the communicator?
2. Invite our chairmen of related committees in for meetings where we can be of service—or the president (president-elect or vice-presidents at her discretion).
3. Briefing from the House of Delegates to the Auxiliary on their decisions and plans.

Incidentally, the auxiliary has stayed within our KMA budget.

Gentlemen, may I extend for the Woman's Auxiliary a charming invitation to you to drop by room 312 of the Kentucky Hotel and enjoy the hospitality and see the hobby show—either Tuesday or Wednesday. Maybe a doctors' and wives' hobby show in the future will spring forth.

Doctors' wives in Kentucky this year have become "live examples" and had "working meetings" through "PLAN—PREPARE—PROJECT," our state theme to carry through the national one of "BETTER HEALTH—BETTER WORLD." At board meetings and conferences: packets were given to each board member on all phases of our auxiliary work so that we might be informed for evaluation of projects; a puppet show in song and word further enhanced our state projects; immunizations were available to make each 100%; Johnny Coats, bandages, drugs, and glasses were brought by each board member; bandages were rolled during the meeting; film, literature and one of our own doctors spoke on water safety and showed the film *Suddenly Upon the Water;* state chairmen reports were enhanced by a clothes line with literature in their field and an article of clothing to focus further upon it; AMA-ERF pageant and a Rural Health Immunization Flip Chart was used. Thus we've been able and knowledgeable to help others in evaluation of community projects as we visit—not only state president and president-elect, but vice-presidents and co-ordinator for members-at-large. Members-at-large have been invited guests and participants.

Rural Kentucky has a membership of 1,525. We have four new auxiliaries—making 30 within 41 counties. Many counties have only 1-3 doctors in some cases in isolated areas. Nearly one-half of these have 100% Members-at-Large. In order for members to have access to information on auxiliary projects, officers, chairmen, important dates, etc., a Guidebook section was added to our Directory. Councilors in some instances set up meetings for the state president to visit; as she would an auxiliary.

Blue Grass News, with its four issues, carried up to date information from state officers, chairmen, president's message, reports from county presidents, Members-at-Large, and started vitaes on board members with pictures.

Statistics for Kentucky to date were stressed in AMA-ERF. Caduceus charms, state charms, net "puffs," and Christmas cards were sold. Other ideas were mentioned at auxiliary visits.

"Block Mother Plan" was begun in at least two counties. Others participated in hospital disaster drills; teaching medical self-help courses; organizing courses in its high schools; working with another organization in sponsoring a course; many members visited the Civil Defense Emergency Hospital set up at convention; programs on some phase of Disaster Preparedness at meetings; and identification tags were furnished the children.

Participation in International Health Activities was spurred on to nearly 100% when each county auxiliary was given a Johnny Coat and package of bandages labeled and wrapped ready to be mailed with theirs by our state president and collected and made by MAL's in her county. Many counties had "working meetings" when she visited by rolling bandages and making Johnny Coats and bibs for retarded children during her talk. A need reported by a doctor and his wife brought us to their aid with glasses, lens, frames, etc. 800 pairs of glasses, 1,000 lenses and 200 contact lens were collected. 200 baby blankets were shipped to Equador.

Medicare vs Eldercare pushed in all phases, educational programs, writing and visiting our congressmen, urging our friends to do so, and speaking engagements with the object being to inform the general public as well as our medical circle of the facts involved in federally controlled health care. All were urged to attend the called KMA House of Delegates meeting to hear Dr. Edward Annis, Dr. Durward Hall, and Dr. T. L. Carter on medicare and eldercare. A list of bills being drafted and those that are already drafted in regard to health for presentation to the Kentucky Legislature when it convenes in 1966 will be distributed at convention this fall. Thus we can be alert and decide where to best direct our strength.

County Health Careers brings four scholarships and nine loan funds, with one student currently using the state loan fund. Students were encouraged by Future Nurses and Health Career Clubs, health career days, candy-stripers and nurses aid training, panels with various health field partioipants, films, literature and, lastly, tours to neighboring cities for first hand observation. Over 600 letters were sent out this year offering our services to all high schools, colleges, and universities in the state. They have on hand our *Loan and Scholarship booklet.*

The navigable miles of waterways are growing in Kentucky to the extent that we will have more than even Alaska when all dams, etc. on the drawing boards at present are in force. Thus, we've chosen to help educate our people on water safety in its many facets. Eight auxiliaries have started this, some in connection with other organizations. Fire prevention, safety in the home, poisons, children and accidents, are others. One auxiliary presents a medal for safe driving to a member of the graduating class, selected by a panel of teachers headed by the driver training instructor. GEMS program was used in three courses in one county and another is preparing the course to use.

A chaplain is now on the board. She has written to the ill, and in case of death, to the family of the deceased. Medicine and religion have gotten a beginning toward improvement.

WA-SAMA liaison between Lexington group and WA-KMA, another first; but also a liaison to organize one in Louisville was successful. It has been a pleasure to visit them as well as a regional group meeting of WA-SAMA.

It is now the Ephriam McDowell Shrine, a National Historic Landmark, as of January 13, 1965, when it was so designated by the Department of Interior. The May 1965 issue of the BULLETIN will show and tell you more.

Other Community service projects were: meals on wheels, health problems of aging, juvenile delinquency, AMA posters, help for handicapped, youth fitness, diabetes detection and education, medical quackery,

AMA pamphlet racks, nutritional delinquency, glaucoma screening, industrial committees, aid to public health departments, and visual and audiology testing. 10,000 children were tested in visual screening by one auxiliary in a two month period with 1,800 having one or more eye defects. This state community service committee for the tenth consecutive year will give a health citation award at convention to a lay person or organization for an outstanding contribution in the field of health. MAL's as well as county auxiliaries have submitted nominations.

The vital field of mental health bounded to the forefront, both in education and volunteer work. "Mirror to the Mind" records are still being used by the county radio stations with 16 already covered. A compilation was done of the mental health facilities in the 10 counties reporting. Mental health activities with programs concerning all phases of work and facilities plus volunteer work with clerical help; sewing of draperies and apron bibs; teaching, etc., to the financial aid through charity balls and fashion shows to send students to camps; aid existing facilities with equipment and personnel; and to help establish new ones. One three-county auxiliary, after re-evaluation, chose one dire need in their community and set up and put into operation a school project for teen-agers in mental health entitled "Behavior and Understanding." Conferences with school guidance counselors suggested subjects including dating, smoking, drinking, school drop-outs, teen-age marriage, emotional development, causes of behavior, family relationships and school relationships. Evaluation of the program by all concerned has made them and us, justly proud.

Kentucky's story is proudly presented by its first member-at-large president, made possible by helping hands from the national, state and county officers, chairmen and headquarters staffs, as well as the total working membership while improving our relationships, and those of our medical families, and the state, as a whole.

Remember—it's up to you to decide and trigger the Woman Power.

Mrs. J. Jack Martin, President,
Woman's Auxiliary to the
Kentucky Medical Association

Recommendations, Reference Committee No. 1

The report of the president of the Woman's Auxiliary has been reviewed and accepted. We approve the three recommendations as contained in this report.

We commend Mrs. Martin and the Auxiliary for their fine work during the past year.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Report of the President-Elect

As your president-elect, I have enjoyed this year very much. It has impressed me to see the many dedicated and hardworking members giving of their talents and abilities. Improved medical care of the patient, medical education of the student, continued training of the practicing physician, maintaining the position of medicine in the free enterprise system and improved relationship with our professional allies were the agenda highlights of every meeting.

The president, the secretary, and the chairman of the Board of Trustees were fine examples of physicians doing their work in a self-sacrificing and self-effacing manner. Also, the entire staff of the KMA home office made every effort to get all information possible on any subject at any time. The executive secretary kept me informed on all communications and all meetings that would have the least bearing on administration this year and next year.

In talking with physicians this year, it has become obvious that many of them should know more about what the KMA and its executives are doing to serve all members. They should know what our home office is doing in so many areas under the guidance and direction of the Board of Trustees, the delegates and the officers.

They need to know about the advantages of our home office ownership and the function of the publication. They need to know of the hours and days contributed by their colleagues in working for favorable legislation, securing scholarship funds, planning postgraduate seminars, working with schools of nursing, meetings with hospital committees and helping with the various problems arising in the most rural or in the largest centers.

When we become more knowledgable of the benefits that we derive in so many areas, it will soon be realized that no investment has a greater return than the money paid for KMA dues.

Your president-elect hopes to continue discussions during the year of the work of your association along with progress and goals now and next year. We look forward to working with the Auxiliary that is filled with incentive and anxious to help us in all ways. We should join hands and repeat as Paul said in his epistle to the Philippians—"We press on toward the goal for the prize of the upward call of God."

Everett H. Baker, M.D.
President-Elect of KMA

Recommendations, Reference Committee No. 1

Reference Committee No. 1 reviewed the report of the president-elect and wish Doctor Baker all success as our incoming president.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Report of the Speaker of the House

We would like to open these remarks, because they apply so obviously to our situation, by quoting for you the words of Milford O. Rouse, M. D., our distinguished Texas colleague, who is speaker of the AMA House of Delegates, when he opened the first session of the AMA House this June in New York. We believe you will agree they are most appropriate here:

> *"This session of our House is a very significant one, with an unusual number of weighty issues for us to consider carefully and decide wisely . . . It has been said that true wisdom is characterized by knowing when to speak your mind and also when to mind your speech. You will never seek conformity nor compulsory unanimity—but we do covet and anticipate wholehearted enthusiastic and willing support of the decisions of the majority, whatever may be the decisions."*

We trust you have studied the many reports made by our officers, councils, committees and boards, which were sent you nearly two weeks ago. Many of our councils and committees have spent countless hours studying problems faced by our profession and our patients during this associational year. Your House of Delegates envelopes contain reports of work that these councils and committees have done and the considered recommendations that they are making to you.

Your speakers urge you to attend and participate in the discussions of the reference committees during this afternoon, starting at 2:00 p.m. in rooms off the mezzanine floor. We hope you will speak freely—but to the point. In each reference committee room will be a blackboard on which the schedule of work for that committee will be listed. So as you move from room to room, you will not only be able to tell what is being discussed, but when to anticipate the taking up by that committee of any special item of interest to you.

For you who are serving the first time in this House, we would point out that after the open hearings in the reference committees and consideration of all reports assigned to it, the committee will go into executive session and formulate its recommendations on these reports. Following the approval of the report by the reference committee, they will be duplicated and each of you will have a copy of each reference committee report when we hold our second meeting Wednesday evening.

On Wednesday night when this House will act on the reference committee reports, your speakers have a request that we feel will undoubtedly facilitate the work of the House. If you have a motion longer than one ordinary sentence, please write it out and give it to the Speaker. We believe you will agree this will insure a better understanding and more accurate presentation of your wishes.

Your speakers would emphasize that no item of business, no resolution or recommendation presented here this morning may in any way be considered the policy of this association until it has been fully discussed in the reference committee and recommendations are made when we meet again Wednesday evening. At that time, you will make the final decision—which will then become the policy of the Association.

Your speakers have appreciated the opportunity of working with and attempting to serve you. Please contact us if we can be of any assistance to you.

And so, in the best tradition of American medicine, with sober confidence, let us approach the momentous responsibilities that are ahead of us.

Garnett J. Sweeney, M. D.
Speaker of the House

Recommendations, Reference Committee No. 1

Mr. Speaker, the reference committee reviewed the report of the Speaker of the House. We wish to thank Doctor Sweeney for the fine job he has done in the past year.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Chairman, Board of Trustees

You will understand, I believe, the concern that I have in making a choice of items to report to you in highlighting the activities of the Board of Trustees during the 1964-1965 associational year when the following is realized. Beginning with the reorganizational meeting of the Board of Trustees on October 1, thru August 5, which covers the period of this report, the Board of Trustees met six times for more than 50 hours, which was covered by 163 pages of minutes.

The Executive Committee has met twice and both the Board and the Executive Committee will hold one more meeting before this report is actually introduced into the House of Delegates.

The minutes of the Board of Trustees and the Executive Committee covering its full activities during the associational year, now closing, are available to any member in the KMA Headquarters office.

There are 28 members of the Board and those invited to meet with it include the alternate delegates to the AMA, deans of the two medical schools, and the health commissioner. Perhaps the single most impressive thing about serving on the Board of Trustees is the high degree of attendance of its members and the depth of interest and dedication that they have in the work the Board must consider. I am deeply grateful for the honor of working with the Board in serving as its chairman this year.

First Meeting—The first meeting was held on October 1 during the last day of the 1964 meeting. The re-organizational session of the Board was called to order by temporary chairman, Henry B. Asman, M.D.

Doctor Asman welcomed the following new members to the Board: Harold B. Barton, M.D., Corbin, vice-president—eastern section; Kenneth M. Eblen, M.D., Henderson, vice-president—western section; Walter L. Cawood, M.D., Ashland, new trustee for the 13th District. He explained that Everett H. Baker, M.D., Louisville, president-elect; Robert W. Lykins, M.D., Louisville, vice-president for the central district; and W. Gerald Edds, M.D., Calhoun, new trustee for the 2nd District, were unable to be present.

Robert E. Pennington, M.D., London, was elected by acclamation.

At this point, Doctor Pennington assumed the chairmanship. On the call for nominations for vice-chairman, Donald Chatham, M.D., Shelbyville, was nominated. He, too, was selected by acclamation. It was then explained that the next order of business would be to select an Executive Committee of the Board, which is composed of the chairman, vice-chairman, president, president-elect, secretary and two additional trustees. Rex E. Hayes, M.D., Glasgow, 6th District; and Hubert C. Jones, M.D., Berea, 11th District; were elected to complete the organization of the Executive Committee.

The advantage of using facilities of the county medical societies to collect the dues of the Kentucky Educational Medical Political Action Committee was next considered in detail, following which the Board voted to accept the general principle and ask the Executive Committee of the Board to implement the matter.

Under the Bylaws of KMA, the Executive Committee of the Board nominates the personnel of the KMA committees, standing committees and councils through the Board of Trustees. At the re-organizational meeting of the Board of Trustees, these nominations were carefully studied by the Board. The next several hours of the Board's time was spent on this matter, going over each group, before the personnel of all the groups was agreed upon.

Second Meeting—The meeting, held on December 10, opened with the report of the president, Delmas M. Clardy, M.D., who gave a summary of his busy schedule, which included a number of speaking engagements.

Following the headquarters office report, submitted by the secretary, Henry B. Asman, M.D., the delegates and alternate delegates to the AMA gave a summary of the activities in the House of Delegates at the 1964 AMA Interim Meeting in Miami.

Recommendations of the Executive Committee for three physicians to be nominated for each of the two vacancies on the State Board of Health were approved.

The name of the Federal Medical Services Committee was changed to Governmental Medical Services Committee and the Executive Committee was instructed to add names of physicians from Eastern Kentucky to the committee.

The Board authorized the Executive Committee to redraft the Oath of Office.

Recommendations of the Technical Advisory Committee to the Governor's Council on Indigent Care were heard and discussed at length. The Board approved the recommendations.

A replacement for an appointee on the Council on Legislative Activities who could not serve, was made. Other recommendations from the Council on Legislative Activities included a revision of the Key Man System, consideration of possible revision of the medical examiner system and the operation of the Hill-Burton program.

The proposal that KMA participate with certain voluntary health groups in health education advertising was approved in principle by the Board and it delegated to the Executive Committee the responsibility of implementing the plan.

Two matters that had been under consideration by the Association in the tield of ethics were referred to the KMA Judicial Council. A request for an appropriation for expenses for the two Senior Day programs was approved. Appreciation was expressed to the District V of Obstetrics and Gynecology for a gift of $1,000 to the McDowell House.

The Board unanimously approved a motion expressing appreciation to the Kentucky Public Health Physicians Association for pledging its full effort towards making the Kerr-Mills program more effective.

Recommendations for membership of the Board of Directors of the Kentucky Education Medical Political Action Committee for 1965 were made and approved. The Board is composed of one member from each congressional district, three members at large and one member from the Woman's Auxiliary.

The Board adjourned after agreeing to meet in Owensboro March 17 in a day long session at Gabe's Restaurant.

Third Meeting—The third meeting of the Board of Trustees was held Thursday, February 4, at the headquarters office. The chairman explained that it was called primarily to discuss the AMA's Eldercare Proposal and an educational program.

The provisions of the Eldercare Program, known as HR 3727, were thoroughly explained to the members of the Board. It was indicated that this bill was based on the Kerr-Mills Program and that it greatly expands the services provided under the present Kerr-Mills Act. The program would be administered by the states.

Mr. Harry Hinton, who at the time was the AMA Field Service Representative, for Kentucky, discussed the bill in some length and clarified questions that members asked.

Following a lengthy discussion, the Board of Trustees voted to support the Eldercare Program and continue resistance to HR 6675.

Consideration was next given to the proposed Educational Campaign to be sponsored by the American Medical Association in connection with the state associations. Plans for this program were carefully outlined and discussed. After full consideration, the Board voted to have this association cooperate with the AMA in the new educational program.

The Board heard a report from G. L. Simpson, M.D., Greenville, chairman of the Governor's Advisory Council on Indigent Care, relative to the operation of the program in Kentucky. The Board was informed that the McDowell Home had been listed by the Department of Interior as a national historic landmark and plans were authorized for having a formal presentation.

The Board voted to activate a cancer coordinating committee, approved the use of the PBX machine and heard an explanation provided by the vice-president of the University of Kentucky Medical Center concerning its policy on student externships.

Fourth Meeting—The meeting held March 17 was called to order at 9:00 at Gabe's Motor Inn at Owensboro, following which the president acquainted the Board with the varied activities of his office.

The report of the AMA delegates on the recent special meeting of the AMA House of Delegates was given by J. Thomas Giannini, M.D., following which Henry B. Asman, M.D., secretary, submitted the report of the Headquarters office. The Board then named a committee to select the date and place for the 1966 Interim Meeting.

Dixie E. Snider, M.D., chairman of the Budget Committee, before presenting the proposed 1965-66 budget, explained that the Budget Committee had spent a full day in making the proposal and that the Executive Committee of the Board had on March 4 reviewed the budget and unanimously recommended it to the Board of Trustees. He pointed out that it was very much like the 1964-65 budget. After careful consideration and discussion, the Board approved the budget.

The Board then heard the recommendation from the specialty group presidents which was forwarded to it through the Council on Scientific Assembly and the Executive Committee that the honorarium for guest scientific speakers at our annual meeting be increased from $50 to $100. Motion to approve this recommendation was made and after discussion was adopted.

On the recommendation of the Council on Legislative Activities the Board approved a waiver prepared by the general counsel, Mr. E. Gaines Davis, Jr., for use by the local grievance committees. The Headquarters office was authorized to send each county society information on this. John C. Quertermous, M.D., chairman of the Council on Legislative Activities for National Affairs, discussed the recent educational campaign.

The Board expressed official appreciation to Hoyt D. Gardner, M.D., for his work in KEMPAC and to Arthur Keeney, M.D., who has chaired the Association's Committee on Highway Safety. Doctor Gardner was unable to serve longer on the KEMPAC Board because of a bylaw limitation and Doctor Keeney is concluding his service as a result of leaving the state.

The Board considered and approved a resolution for consideration by the House of Delegates at the special meeting scheduled for the evening of March 17 and disposed of other matters in this connection. Additions were made to certain committees as a result of resignations. Among other council recommendations were: approval of deactivating the post-graduate fund; decision to set up the fallout shelter in the KMA Headquarters office not as a public shelter due to the smallness of its size; and the approving of a KMA certificate which might be presented by county societies to project winners at science fairs.

There was a lengthy discussion on the programs and activities of the Board of Health by Russell E. Teague, M.D., Commissioner of Health, and by members of the Board of Health. Robert F. Long, M.D., a representative of the Pulaski County Medical Society, reported on the adverse reaction of the members of his group to certain health department activities. Following discussion by members of the Board, a motion was passed referring the matter to a KMA committee to be named by the chairman for study.

Miscellaneous reports were heard and acted upon and there were several who made progress reports.

The Board, following a reading of a communication from the Kentucky Hospital Association on the matter of licensing foreign physicians, named a special committee to meet with representatives of the hospital association to study the problem.

The Board adjourned at 4:00 p.m.

Fifth Meeting—Current legislative proposals now pending in the Congress occupied the major portion of consideration by members and guests of the Board of Trustees at a special meeting Thursday, June 3, in Louisville at the Headquarters Office.

The meeting was called by the Chairman of the Board, Robert E. Pennington, M.D., London, for the purpose of briefing members of the Board and others on how these proposals, if enacted, might affect the practice of medicine in Kentucky. Between fifty-five and sixty attended.

Mr. Aubrey Gates, Chicago, director of the AMA Field Service and a member of the AMA Legislative Task Force, along with Mr. James Foristel of the AMA Washington Office, who in addition to being a lobbyist is an analyst of legislative proposals, were most effective in presenting and analyzing the issues. Both members and guests expressed gratification in the amount of material covered during the meeting and for the contributions made by the special guests.

It was not anticipated that the Board would take

any action on any of these proposals since the meeting was designated as a "think session." However, just before the recessing for lunch, guests were temporarily excused and the members of the Board acted on a few matters requiring early attention.

At this time the Board without dissent voted to support the proposed $176,000,000 state bond issue, which will be voted on in the November general election.

Sixth Meeting—The sixth meeting of the Board at the Headquarters Office held August 4 and 5 considered a 43-item agenda. The president's report reviewed in some detail the AMA President's inaugural address, the material considered by the AMA House of Delegates late in June relating to the amendments to the Social Security Act of 1965, and the final action the AMA House of Delegates took on this issue. Doctor Clardy's report called attention to the Bauer Resolution, Section 6 of the Code of Ethics and the nine principles of medical care that the AMA House had approved.

Doctor Clardy stated that the AMA Board of Trustees would meet the next day and he felt that KMA should give the AMA its position on what course should be followed, now that HR 6675 (Amendments to Social Security) had passed the Congress and was now known as Public Law 89-97. President Clardy felt that the AMA House should now call a special session and take steps to "satisfy the disturbed membership of the AMA".

Before action was taken, the Report of the KMA Delegates, presented by John C. Quertermous, M.D., was heard. Following this report, and after full discussion, the Board of Trustees authorized the following message to be telegraphed to the AMA:

> *"The Board of Trustees of the Kentucky Medical Association, meeting on August 5, 1965, wishes to make the following resolution to the Board of Trustees of the American Medical Association that in compliance with the second paragraph of the amended portion of the Report of Reference Committee on Legislation and Public Relations (A-65), as adopted by the House of Delegates of the American Medical Association at the Annual Session, June 24, 1965: 'Resolved, that when the fate of the pending Medicare legislation is determined, this House will review, in special session, if necessary, the effect of the law and take whatever action is deemed necessary;' and therefore, since public law 89-97 is in fact a law, that a special called session of the House of Delegates, AMA, be made the earliest possible date to consider 'the effect of the law.'"*

The KMA Bylaws provide that the Board shall meet at least six weeks before the Annual Meeting and review the reports of the Councils and standing committee reports to the House of Delegates, and give the delegates the benefit of its reaction to these reports—but not to alter any of them. This was the first order of business.

At this point, your chairman, on behalf of the Board, commended these councils and committees on the tremendous amount of work done during the 1964-65 associational year and the contribution they have made to the public and the members of the profession.

Because of the need for immediate action, the Board was asked to pass on certain recommendations from committees and councils. The KMA Committee on Hospitals, for example, recommended that the KMA and the Kentucky Hospital Association take the lead in forming a voluntary area-wide Hospital Planning Commission for Kentucky. Following a lengthy discussion, this recommendation was approved.

The Council on Medical Education and Hospitals asked of the Board permission to duplicate and include in the House of Delegates envelope a summary of an important 31 page-study it had conducted on medical education. This was approved. A third request relating to cooperation with the Kentucky Hospital Association in preparing and distributing a pamphlet on emergency room procedures was accepted.

At the recommendation of the Council on Allied Professions and Related Groups, the Board voted to increase the size of the liaison committee with dental, nursing and pharmacy professions, in order to consult with these groups more effectively. A second special recommendation to the Board from this council, which would have set up a new committee, was declined.

Recently, the AMA suggested the appointment of a joint liaison committee between the medical and nursing professions to consider guidelines for nurses in relation to services performed in hospitals. This committee has met and made five recommendations, which were accepted with one slight alteration.

The Board approved a request of the Kentucky Educational Medical Political Action Committee, which asked to be invited to participate to the extent of 15 or 20 minutes in each of the Trustee District meetings held during the 1965-66 associational year.

In a series of special recommendations to the Board—separate and apart from the report to the House of Delegates—from the Council on Legislative Activities, the Board voted to support efforts to improve the medical examiner system, revise the KMA Legislative Key Man system, resist enactment of current heart, cancer, and stroke proposals in Congress pending further study, and resist any changes in the present structure of the State Board of Health.

The Board also voted to appoint a long range ad hoc committee of the Board to study the implementation of Public Law 89-97 and advise the Board on the new law's operation and make recommendations.

Consideration was given to the nominations for membership on the Judicial Council, as provided for in the By-laws as adopted at the 1964 KMA House of Delegates. This will be a separate recommendation of the Board to the House.

Long and careful consideration was given to the proposals for the implementation of Public Law 89-4, which provides for the establishment of regional multi-county health centers. The chairman reported that less than 5 percent of the counties in the 40-odd county area involved were even aware of this program, and there had been relatively no consultation by the authorities with local county medical societies. Grave concern over the effects of this program on the physician supply in outlying areas, county health departments, administration, etc., was expressed. Since the Governor has the final decision in this matter, the Board elected a committee to seek a conference with the Governor at an early date on this important matter.

Robert E. Pennington, M.D., Chairman
KMA Board of Trustees

Recommendations, Reference Committee No. 1

The reference committee reviewed in detail the report of the Board of Trustees. We would again like to express appreciation to Hoyt D. Gardner, M.D., for his work in KEMPAC and to Arthur Keeney, M.D., who has been the chairman of the Committee on Highway Safety during the past several years.

We also agree that a conference with the Governor concerning the regional multi-county health centers should be arranged for an early date.

We agree that there should be no changes in the present structure of the State Board of Health.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Secretary

One year ago, in reporting to this House of Delegates, I expressed the opinion that the Association was in good hands, that your money was being well-spent, and that the image of Medicine in Kentucky was being adequately safe-guarded and capably presented to the public.

Events that have transpired during the ensuing twelve months would, I believe, confirm that judgment. You have been represented by a dedicated, conscientious and unselfish group of officers, Board members, Council and Committee members, and Administrative Staff.

To illustrate briefly the amount of time and effort contributed by countless physicians to the affairs of the Association I would burden you, for a moment, with a few statistics. These figures are for the present associational year—October 1, 1964 through August 15, 1965—and do not include any part of the last Annual Meeting.

During these ten and one-half months the Board of Trustees and/or the Executive Committee met on seven occasions. Two of these meetings were two-day sessions. The meetings were "in session" a total of 48 hours (six eight-hour working days), and represented a total of 1,026 hours contributed by the members of the Board. In order to attend these meetings the members travelled more than 33,000 miles; and reducing that to "travel time" we come up with another 700-plus hours away from his office and practice.

KMA Councils and Committees held a total of 59 meetings, in session for a total of 169 hours and consuming 875 physician-hours. These members of the Association travelled a total of nearly 50,000 miles in order to take part in these meetings. These physicians, I need not tell you, received no monetary remuneration for their time, travel or lodging.

The four members of our Executive staff attended and/or serviced all KMA meetings, many meetings of related groups, and some out-of state meetings. Keeping in mind that it is sometimes necessary, or desirable, for more than one staff man to attend a given meeting, we find that they have worked a total of 256 meetings involving 985 hours.

It should be pointed out again that this tremendous volume of work and time-consuming effort is in response to the By-laws of this Association and the policies dictated by this House in an effort to fulfill the purposes of our Association in these complicated times.

During the past year a number of misunderstandings have arisen in regard to procedural matters. These have usually resulted from a failure to refer to the By-laws or, perhaps, to a mis-interpretation of the By-laws.

1. Chapter I, Section I states that "Membership in this Association shall be coterminous with membership in a component county society". This means that a physician cannot be an active member of his county society and an "inactive" member of KMA, or vice versa. He must hold the same classification of membership in both groups.

2. Chapter IX, Section 2 reads "Any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met". A number of county societies have been negligent in the application of these two sections in the past. This will be called to the attention of the Board of Trustees for consideration at an early meeting with an eye toward stricter enforcement of these provisions. I would urge the delegates to encourage their county officers to greater diligence in these matters lest the members be deprived of the benefits of membership in the Association, and their delegates be disqualified from participating in the deliberations of this House.

3. Along this same line, I would point out to you that, as delegates representing your county society, you have a responsibility to report back to your society concerning the proceedings of this House, and especially on any and all matters pertaining to or directly affecting your local society. As an example: By action of the 1964 House of Delegates, a mandatory Orientation Course was established as one of the requirements for active membership in the Association. When preliminary information concerning the Orientation Course was mailed out a short time later, the Headquarters office soon began to receive replies and inquiries which indicated that many county society officers and members had no knowledge at all that this had been established as official policy of the Association by an amendment to the By-laws. It is recommended, therefore, that the delegates, or chairman of the delegation, make a detailed report of the actions of the House at the first meeting of his county society following this Annual Meeting.

4. Your attention is called to an amendment to Chapter VIII, Section 4, which will be submitted a bit later. It is occasionally expedient that a committee of the Association hold a meeting in a place other than the Headquarters office. In the interest of efficiency and coordination, however, it is essential that all such meetings be set-up by, and notices sent out by, the Headquarters staff. Your favorable consideration of this amendment is urged.

In the Report of the President, Doctor Clardy has encouraged closer liaison between KMA and the component county societies—a most worthwhile recommendation deserving of our special attention and concerted efforts. In this connection I would remind you of the services of our director of field services, Mr. Gil Armstrong, who has joined our administrative staff since the last Annual Meeting. During the first three months of 1966, Mr. Armstrong will be pretty well confined to Frankfort for the session of the State Legislature. At all other times, however, he is available to the component societies and individual members for information and service, and will be happy to assist in arranging programs for meetings. Insofar as time will permit, Mr. Armstrong will visit every county in the Commonwealth during the coming year, contacting county society officials and members and bringing the services of KMA to your door. When he does call on you, may I request that you give him a few moments of your time—as promptly as possible. Remember—he has a big territory—119 other counties, and almost two thousand other members!

The officers of the Association and other members of the Administrative Staff will also be happy to discuss the plans and programs of KMA at meetings of county societies or trustee districts. Arrangements for such programs can be made through Mr. Armstrong or by contacting the Headquarters office.

Henry B. Asman, M.D.
Secretary

Recommendations, Reference Committee No. 1

The reference committee approves the report of the secretary and again would like to remind you of the services of the director of field services, Mr. Gil Armstrong.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Editor

During the past year, twelve issues of the Journal have been distributed to the members, usually at about the 10th of each month. There has been one special issue, May '65, carrying papers presented at the Norton Memorial Infirmary Seminar. An insert by Kentucky Physicians Mutual distributed with the October '64 Journal; another insert by Blue Shield is planned.

A readership poll was carried out at suggestion of the State Medical Journal Advertising Bureau. A response of 13 percent of members was obtained. This is better than the average of State Medical Journals participating in the poll. Revenue from advertising has shown an encouraging increase. We do not now employ anyone to solicit local advertising. This comes through the agency of SMJAB.

Blaine Lewis, M.D., Louisville, is chairman of the Advisory Committee to the Editor. Other members of the committee are P. J. Murphy, M.D., Lebanon Junction; Gerald B. Reams, M.D., Ashland; Willett H. Rush, M.D., Frankfort; Frederick Scott, M.D., Madisonville; and Orson P. Smith, M.D., Louisville. At a meeting July 22, 1965, this committee reviewed in detail the affairs of the Journal and generally reported favorably on its activities. The present policy of placing 50 copies of the Journal in the library of both medical schools each month, was approved. Since these Journals are all taken by the students, the committee felt that more should be placed at their disposal. After considering change of the cover, it was decided to continue the present cover for at least one more year. Consultants to the scientific editor were approved to replace those retiring in 1965.

Sam A. Overstreet, M.D.
Editor

Recommendations, Reference Committee No. 1

The reference committee reviewed the report of the Editor and accepted the report as written.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Treasurer* **

Recommendations, Reference Committee No. 1

The report as prepared by Doctor Smith and also the audit of Christen, Brown & Rufer, Certified Public Accountants, was approved as submitted.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Report of the AMA Delegates

The delegates to the AMA from the KMA herein submits its annual report. The object of this report is to bring to the attention of this House the most significant actions of the AMA House of Delegates.

A. The 18th clinical meeting met in Miami Beach, Florida on November 30 to December 2, 1964.

The following matters were acted upon:

1. Reaffirmed AMA policy of strong support action by the states in continuing the improvement of the implementation of Kerr-Mills program.
2. Authorized an expanded educational program concurring with the Kerr-Mills programs.
3. Resolutions submitted by KMA:

a. KMA delegation resolution "Hospital Signs on Highways" The AMA House of Delegates recommended "that the intent of this resolution be adopted in principle with implementation to be undertaken by the committees and staff of the AMA under the guidance of the Board of Trustees."

b. KMA delegation resolution "Straight Internship vs Rotating Internships", House of Delegates AMA, voted to refer this resolution to the Committee on Education for Family Practice of the Council on Medical Education.

c. KMA delegation resolution "Private Hospital Internships" AMA House of Delegates voted not to adopt this resolution.

d. KMA delegation resolution "Participation in new Third Party Plans"

AMA House of Delegates voted not to adopt this resolution because "it believes, that the objectives of this resolution are adequately met by existing policy statements of this House of Delegates."

B. A special session of the AMA House of Delegates was called at Chicago, Illinois, February 6-7, 1965.

This meeting in a 2-day special session was to review current health care legislation.

The House of Delegates of the AMA gave unanimous approval and support to the AMA Eldercare Program and to the Herlong-Curtis Eldercare Bill (HR 3727). The House of Delegates also:

1. Reaffirmed its opposition to the King-Anderson Bill (HR 1 and S 1) and all similar measures;
2. Called for study of the "desirability and feasibility of extending the principle and state aid under the Kerr-Mills principle to persons below the age of 65 who need help;"
3. Adopted a statement on Standards for Health Care Programs:

a. No person needing health care shall be denied such care because of inability to pay for it.

b. It is appropriate that government revenues be used to finance health care when other resources have been found to be inadequate.

c. Every level of government (municipal, county, state, and federal) should assume a responsible share in the financing of such programs.

d. The health care provided by such programs should be adequate and should be equal in quality to that available to those who can afford to pay.

e. Maximum use should be made of voluntary prepayment and insurance mechanisms.

f. Administration of such a program should be the responsibility of the state government. Participating states should be required to meet adequate standards of administration in order to qualify for federal funds.

g. Eligibility requirements for benefits should be fair, realistic, uncomplicated and practical.

h. Any such health care program should provide funds only, and not direct services.

i. Funds for such programs should come from general tax revenue and not from Social Security taxes.

4. Urged that the professional services of pathologists, radiologists, physiatrists and anesthesiologists should be excluded from the provisions of any bill which excludes other physicians' services.

C. The 114th Annual Convention met in New York City, June 20-24, 1965.

Federal health care legislation and the report of

(Note: Any member wishing to see a copy of the Treasurer's Report may do so by writing the KMA Headquarters Office, 3532 Janet Avenue, Louisville, Kentucky 40205.)

***Please see November Journal of KMA Organization Section page 908 for graph showing distribution of KMA funds.*

the President's Commission on Heart Disease, Cancer, and Stroke were the two "big problems" considered by the AMA House of Delegates.

1. Health Care Legislation:
Most controversial issue before the House was that of non-participation under any so-called "Medicare" law that might be passed by Congress. This subject came up in various ways in nine resolutions and in portions of Doctor Appel's inaugural address.

The House recommended that "the members of the American Medical Association be reminded that it is each individual physician's obligation to decide for himself whether the conditions of a case for which he is about to accept responsibility permit him to provide his own highest quality of medical care." In adopting a substitute resolution, the House declared that "the physicians of the United States of America pledge themselves to continue their search and activity, in whatever social environment may develop, to secure or to restore the freedom, high quality and availability of medical care which has been traditional in our country."
"When the fate of the pending medicare legislation is determined, this House will review, in special session if necessary, the effect of the law and take whatever action is deemed necessary."
"In keeping with the testimony before your committee, and the expressed policies of this House, this action should in *no* way be interpreted as a change in Section 6 of the 'Principles of Ethics' of the American Medical Association which plainly states: 'A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgement and skill or tend to cause a deterioration of the quality of medical care;' " and that this House of Delegates reaffirm the principles of the Bauer amendment adopted in 1961.

The Bauer Amendment:
"The House of Delegates of the American Medical Association believes the medical profession will see to it that every person receives the best possible medical care regardless of ability to pay, and it further believes 'That the medical profession will render that care according to the system it believes is in the public interest, and that it will not be a willing party to implementing any system which it believes to be detrimental to the public welfare.' "
2. President's Commission on Heart Disease, Cancer, and Stroke:
The House of Delegates of the AMA considered seven resolutions involving the report of the DeBakey Commission and adopted the following substitute statements:

"The American Medical Association points with pride to the immense strides made in the approaches to the conquest of heart disease, cancer, and stroke under existing patterns of research and medical practice; strongly favoring the use of available financial support for extension of these patterns rather than replacement by a complex of medical control centers and satellites.

"The American Medical Association opposes those particular Commission recommendations which call for and have stimulated proposals for hastily contrived and unproven sweeping changes in the pattern of medical research, education, and patient care.

"The component state medical associations be urged to conduct conferences with medical educators and scientists, medical staffs of hospitals, medical society representatives, and other interested parties, for the purpose of exchanging information and for the development of such recommendations as may be appropriate for the continued improvement of medical education, research, and patient care.

"The state medical associations be urged to report findings and recommendations resulting from these conferences to the AMA Board of Trustees, for the information of the Board, its councils, and the Association members."

This House of Delegates will recall that the proceedings of the AMA House of Delegates are published in some detail in the Journal of KMA and therefore additional action and activities of the 1964 AMA clinical session and 1965 AMA annual session will not be discussed in this report.

Finally, the delegates and alternate delegates, J. Thomas Giannini, M.D., John Quertermous, M.D., Charles Rutledge, M.D., Charles G. Bryant, M.D., William W. Hall, M.D., join with me in expressing our thanks and deep gratitude for the assistance of the many Kentucky physicians and their wives who were so very helpful to us on conducting the business of the delegates.

We also wish to thank Joseph Sanford and Bob Cox for their invaluable assistance.

Wyatt Norvell, M.D.,
Senior Delegate to the AMA

Recommendations, Reference Committee No. 1

The report of the AMA Delegates was approved by the reference committee and we wish to thank J. Thomas Giannini, M.D., John Quertermous, M.D., Charles Rutledge, M.D., Charles G. Bryant, M.D., William W. Hall, M.D. and Wyatt Norvell, M.D. for their fine job in the past year.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Executive Secretary

To report on all of the activities of the Headquarters office staff in order that you might know the extent of the work being carried on seems very desirable. However, such a report would be so voluminous it would not be feasible. We will try, however, to highlight what is taking place in five major categories. As the Association increases its services and programs, there is, of course, a corresponding expansion of Headquarters office activity.

1. *Servicing of Committees, Councils, Board of Trustees and House of Delegates Meeting.* Nearly 400 headquarters staff hours were spent in servicing meetings of committees, councils, and Board of Trustees during this Associational year. This includes the recently established Judicial Council. Responsibilities in this area include the setting up of meetings, researching of agendas, notification of members, writing the minutes and implementing the action of these groups under appropriate supervision.

The approximately 265 pages of mimeographed material in your House of Delegates envelope, covering some 60 reports of officers, standing special committees, plus the six councils (these have 36 committees under them), reflect to a considerable degree the amount of staff work involved in behalf of these groups.

2. *Continuing major projects.* Under this category are the Annual Meeting, the Journal, KMA Communicator, and the Rural Kentucky Medical Scholarship Fund.

The Annual Meeting preparation constitutes a year-round staff activity; for instance, there are more than 100 technical and scientific exhibits presented at this meeting. This is the product of staff effort that began immediately after the 1964 meeting closed.

Each exhibit will involve the writing of at least five letters during the Associational year. The seventy-five technical exhibits now provide approximately seven percent of the Association's annual income.

On the scientific program side, the staff has been actively involved in arranging for twenty half-day programs during the three-day sessions. This requires countless letters and phone calls and the making of arrangements and meeting deadlines. There are some sixty-odd speakers who are committed, sixteen of whom are from other states. The staff makes hotel arrangements, provides necessary service for speakers, visual aids, etc.

We are grateful for the opportunity of meeting with the editor and associate editor in the headquarters office every other Monday morning at seven-thirty to plan the work of the Journal. Material must be assembled, organizational copy written and deadlines met, in the twelve departments for each issue of the Journal.

The newsletter—The KMA Communicator—is prepared, processed and mailed under the supervision of our secretary. In addition, there are numerous news releases and promotional layouts and mass mailings carried on by the staff.

One very important part of this category is staffing the Rural Kentucky Medical Scholarship program. Numerous meetings and countless interviews are held in addition to considerable bookkeeping and letter writing that is called for in following the 250-odd recipients of the Fund.

3. *The next category is special projects.* The recently established Orientation Program for new members which will be given twice a year has added a very considerable load to staff in the way of preparing for meetings, writing of hundreds of letters and carrying out special assignments. The staff is delighted in having a part in this progressive program.

Under supervision of the Senior Day Committee, the staff now has major responsibilities in promoting the two Senior Day Programs, one at the University of Louisville and one at the University of Kentucky.

The annual Rural Health Conference involves many meetings with related groups who are cooperating in presenting the conference, preparation and distribution of promotional material and making arrangements.

Two very important public service programs of the Association are the Diabetes Detection and Immunization Drives. The Immunization program is presented in the spring and the Diabetes Detection in the fall. These valuable services are well recognized by the public, and receive appropriate press coverage —numerous contacts with cooperating groups and great amounts of promotional material are prepared and distributed in these two programs.

The second most important single meeting sponsored each year by the Association is the Interim Meeting. Working under the supervision of the Program Committee, the staff makes arrangements for the meeting, commits speakers, and carries out promotion of it.

Another of the special projects held during this year, which is very much in evidence in your House of Delegates envelope, is the analysis of the medical education questionnaire which was distributed to all members of the Association, collected and correllated. This work was done by our staff.

A very time-consuming but worthwhile program is the arranging for and staffing of health education exhibits at such important opportunities as the Kentucky State Fair, Kentucky Education Association, and other special occasions. This is another opportunity to serve the people in Kentucky.

This last and perhaps most important of all KMA special activity is working in the biennial Kentucky General Assembly. Not only does this involve extra meetings of the Council on Legislative Activities, but our lobbyist is kept on the scene in Frankfort throughout the legislative session. In addition, he makes it his business to become acquainted with these legislators prior to the time the session will be held, the next of which is January 1966. It is necessary to scan literally hundreds of bills while the legislature is in session, which in one way or another might involve health-related issues. It is the responsibility of the lobbyist to be informed and sensitive to trends and report these to the Council on Legislative Activities.

4. *Administrative.* Responsibilities in this area are never very dramatic, but are highly important to a high volume operation and time consuming. Some of the more important phases of this includes departmental and individual staff supervision, recruitment, purchasing of supplies, maintenance of office equipment and buildings and grounds.

5. *The final category includes miscellaneous activities.* One of the functions of the executive staff is to represent the Association at meetings of related interest. Your staff seeks to interpret KMA policy and purposes, and at the same time bring back information on what related and allied groups are doing. This two-way street is both necessary and profitable. Another highly time-consuming miscellaneous responsibility involves the cooperation with numerous AMA requests, especially in the field of legislation. This past Associational year has seen an unusual amount of activity in this area. One recent request of a highly important nature involved more than a week of one staff member's time in obtaining the necessary material for AMA.

The telephone, that "thoroughly necessary evil", seems to require an increasing amount of attention. Every effort is made to take care of these calls in a way that will provide an efficient and cheerful service to the membership and the public. Some days as many as seventy-five calls will be handled.

As the Association work expands, the number of people to be seen in the office shows a corresponding increase: For example, there are many callers in connection with the placement service and Rural Scholarship programs. Here, again, every effort is made to provide prompt and efficient service.

Nothing pleases the staff more than the opportunity to have you, the membership, call at the building. It is a pleasure to explain our operation to you, show you through our building, and to render any service that you may require. You are welcome at all times.

The staff joins me in expressing deep appreciation for the kind, considerate and excellent supervision and direction given us by our president, chairman of the Board of Trustees, speaker and vice-speaker of the House, the editor of the Journal and his associates and all council and committee chairmen. We are grateful for the opportunity of serving you and for your tolerance of our short-comings.

We would also like to pay tribute to our secretary and treasurer, whose service to the Association may often be taken for granted by the membership. Your secretary has spent approximately 60 hours conferring with and giving direction to the executive secretary this past year. Your treasurer is asked to sign hundreds of checks over a period of a year. Your staff leans heavily on the advice of these two officers.

And, in conclusion, may I convey my unbounded gratitude to the other members of the headquarters staff. I would like to commend each member for his dedication, cooperation and solid record of performance in carrying out his assignments.

J. P. Sanford
Executive Secretary

Recommendations, Reference Committee No. 1

The reference committee approved the report of the executive secretary and wish to thank Mr. San-

ford for his continued enthusiasm and devotion to the State Medical Association.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Council on Communications and Public Service

[Page 15, paragraphs 2 and 3 (Senior Day Committee)]

At the committee's meeting on December 3, 1964, members requested the Board of Trustees to appropriate $500 each year for the committee's use in paying for guest speakers' honoraria. This amount was requested to be set aside each year so that there will be no doubt at the last minute as to whether or not the money will be available.

COUNCIL ACTION: It is recommended that the report of the Senior Day Committee be accepted as presented. The Council wholeheartedly agrees with the Committee and recommends that $500.00 be automatically set aside each year for the Senior Day Committee's budget for use when needed in securing guest speakers.

Recommendations, Reference Committee No. 1

The reference committee recommends that $500.00 be automatically set aside each year for the Senior Day Committee's Budget for use when needed in securing guest speakers.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Council on Allied Professions and Related Groups

[Paragraph VI (Committee on Perinatal Mortality and Morbidity)]

VI. Modification of the reorganization of the Committee on Perinatal Mortality and Morbidity. The committee would like to recommend to the Council on Allied Professions and Related Groups, that some reorganization of the Perinatal Mortality and Morbidity Study Committee might be in order in that we would like to see appointed on next year's committee in addition to men primarily interested in the field of pediatrics, an obstetrician, an anesthesiologist, and a pathologist. We feel that the addition of these three allied specialties would enable the committee to function more efficiently in the detail studies of the problems that might be presented to such a committee. It was noted that in many cases the opinion of an obstetrician would be helpful, particularly in the study of individual cases and diseases. An anesthesiologist would be helpful to the committee in its efforts to improve resussitation procedures of the premature newborn and a pathologist would be able to add valuable interpretation in the discussion of case material which might be presented to this committee.

Recommendations, Reference Committee No. 1

The reference committee agrees with the reorganization of the Committee on Perinatal Mortality and Morbidity and agrees that an obstetrician, anesthesiologist and pathologist be included on the committee.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Mr. Speaker, I move the adoption of this section of the report as a whole. (Motion was seconded and carried.)

I would like to thank members of Reference Committee No. 1 for their most needed help and diligent and dedicated work on this committee.

REFERENCE COMMITTEE NO. 1
Robert T. Longshore, M.D., Covington, Chairman
Carl Brueggemann, M.D., Covington
Thomson R. Bryant, Jr., M.D., Lexington
Mary Pauline Fox, M.D., Hazard
Joseph H. Kurre, M.D., Owensboro

REFERENCE COMMITTEE NO. 2†

E. C. Seeley, M.D., Chairman

Reports on Scientific Assembly and Medical Education

†*See note (†) bottom of column one, page 972.*

Reference Committee No. 2 considered the following reports:

11. Report of the Council on Scientific Assembly
12. Report of the Council on Medical Education and Hospitals
14. Report of the Council on Medical Services, page two, paragraphs two and four

Resolution C—Commendation of University of Kentucky Medical Center

Report of the Council on Scientific Assembly

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the Bylaws, which reads in part:

". . . . Each standing committee and council shall report annually at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make"

The material in this report of the Council on Scientific Assembly is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each commitee report.*
3. *Recommendations by the KMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * * *

The first business of the 1964-65 Council on Scientific Assembly was to review the operation of the Annual Meeting Scientific Sessions, held in the new Convention Center at the 1964 session. This was the first meeting held in the Convention Center since it was reconstructed and redecorated. Members of the Council generally were well satisfied with the layout and decided to make no recommended changes. Concern was felt by some of the members about noise that drifted from the technical exhibit hall into the scientific assembly room.

Two steps have been taken to reduce this noise for the '65 meeting. The first is to move the entire

exhibit hall toward the west ten feet and create a "dead space" between the meeting room and the exhibit hall. Heavy curtains will be used again this year as they were last. The second step to reduce the noise will be to hang long heavy curtains at the east and west ends of the scientific assembly room.

Approval by the various specialty groups of the facilities offered by the Convention Center for their afternoon specialty group meetings was noted with appreciation. The facilities of the Convention Center permit all scientific meetings to be held under one roof.

The Council is pleased to report that we have sixteen specialty groups meeting in connection with the Annual Session this year, which is an all-time high. The Council would like to express its appreciation to the various specialty groups for their cooperation.

At the request of the specialty groups, the Council presented a recommendation to the Board of Trustees that the honorarium for guest speakers be increased from $50 to $100. This recommendation was acted on favorably by the Board.

The Council wishes to express appreciation to the Southern Bell Telephone Company for again sponsoring the Message Center in the heart of the Technical Exhibit Hall. This is indeed a most valuable service to the Association and to its members.

The Council would also like to express its appreciation to the Scientific Program Committee, which has put together a most interesting and worth-while program. It wishes also to express its appreciation to the other committees of the Council for their very fine cooperation in making this meeting possible. Certainly, the members of KMA owe these committees and the physicians serving on them a deep debt of gratitude for the many hours of work that have been contributed to the success of the meeting.

The following reports of the committees serving under the council are herewith submitted:

Recommendations, Reference Committee No. 2

This report was considered as a whole and the reports of its component committees. The members of the committee felt that the Council on Scientific Assembly should be commended for its fine work in planning the Scientific Program for this year.

Scientific Program Committee

Douglas M. Haynes, M.D., Louisville, Chairman

Your committee has held two meetings during the past year. In addition, representatives of this committee met with the presidents of the sixteen cooperating specialty groups to explain plans for the 1965 scientific program and the participation of the cooperating specialty groups.

Your chairman, along with members of the KMA staff, have held countless conversations on the telephone and written innumerable letters in putting this program together.

Virtually the same format as used at the 1964 meeting will be used again this year. It is a combination of two widely different programming systems that have been employed in the past.

Especially do we want to express appreciation to Walter S. Coe, M.D., for planning and presenting under the sponsorship of Smith Kline & French, to whom we are all very grateful, the excellent symposium on coronary heart disease. We have never presented anything just like this before. We trust it will be profitable.

Recommendations, Reference Committee No. 2

The report of the Scientific Program Committee was studied and we would like to take this opportunity to congratulate this committee on its fine work.

Mr. Speaker, I move the adoption of this section of this report. (Motion was seconded and carried.)

Scientific Exhibits Committee

Benjamin B. Jackson, M.D., Louisville, Chairman

The KMA Scientific Exhibits Committee will meet July 22 to review applications and select exhibitors for the 1965 KMA Annual Meeting. This report is being submitted in advance of our meeting date so that it can be included in the report of the Council on Scientific Assembly and forwarded to the KMA Board of Trustees for consideration. It is anticipated that approximately twenty exhibits will be approved for presentation. All exhibits are scheduled to be in place by 8:00 a.m., Tuesday, September 21, and are not to be removed until 3:30 p.m., Thursday, September 23.

A special committee will judge the exhibits on Tuesday morning and select a first, second and third place winner. The first place winner will be presented a plaque during the Scientific Session Wednesday morning, September 22. The committee is revising a certificate of appreciation, which will be signed by the KMA President and Chairman of the Board of Trustees, and presented to each exhibitor.

Members of the committee are most appreciative for the continuing interest in Scientific Exhibits.

Recommendations, Reference Committee No. 2

This report was studied and it is felt that this committee has upheld the fine tradition of its predecessors.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Technical Exhibits Committee

Clyde T. Moore, M.D., Louisville, Chairman

Your committee wishes to report that all available booths in the Technical Exhibit Hall, 75 in number, have been absorbed again this year. This is the same number, an all-time high, that we had last year.

Once more, your committee urges all members of the House of Delegates and the Association members attending the meeting to attend as many of the exhibits as possible. It is doubtful that you can obtain more authentic information in as little time and with as small effort, which is so necessary in your day-to-day practice, than you can obtain in our technical exhibit hall.

The members of our committee would like to express their appreciation as well as that of the Association to each one of our exhibitors for supporting our annual session. Not only do they provide the important service we have described above, but through the rental paid for booth space, our exhibitors make possible the very fine Annual Meeting that we enjoy without any registration fee on the part of the members.

You will recall that last year two experiments were undertaken in the Technical Exhibit Hall. One was the Message Center, which proved to be quite successful and is being repeated again this year. It is being sponsored by the Southern Bell Telephone Company. The other related to "three-sided booths." While some of the exhibitors felt the experiment should be continued, general support for the idea, however, was lacking. We think the problem existed in a breakdown of communications between the home office of the company and the field staff. It was obvious that the purpose of the three-sided booths was misunderstood by the exhibitors, and the idea has been dropped.

Recommendations, Reference Committee No. 2

This report was studied and your reference committee wishes to emphasize the urging of the committee that all members of the Association attend as many of the exhibits as possible.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Golf Committee

James B. Douglas, M.D., Louisville, Chairman

The Golf Committee held no official meeting this year since arrangements for the 1965 KMAGA Golf Tournament are similar to those of last year. Your chairman did canvass the committee members by mail to obtain any specific suggestions they might have in planning the tournament.

Due to previous action by the KMA House of Delegates, the Annual Golf Tournament will be held on the Monday preceding the opening of the KMA Annual Meeting. Your committee has announced that this year's tournament will be held at the Louisville Country Club on Monday, September 20.

In order to participate in the 1965 tournament, the golf committee would accept only those applications received before September 1, 1965. Publicity, prizes, and other aspects of the tournament will be the same as in the past.

Arrangements were made with the KEMPAC Board of Directors to present trophies at the dinner-meeting on September 20. This gives the golfers and their wives an opportunity to hear several outstanding speakers on the KEMPAC Program.

COUNCIL ON SCIENTIFIC ASSEMBLY
Delmas M. Clardy, M.D., Hopkinsville, Chairman
Everett H. Baker, M.D., Louisville, Vice-Chairman
Harvey Chenault, M.D., Lexington
Douglas M. Haynes, M.D., Louisville
Benjamin B. Jackson, M.D., Louisville
Clyde T. Moore, M.D., Louisville
Edmund D. Pellegrino, M.D., Lexington

Recommendations, Reference Committee No. 2

This report was studied and it was noted that no meeting had been necessary since the arrangements for the 1965 Golf Tournament had already been made.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Mr. Speaker, I move the adoption of the report of the Council on Scientific Assembly. (Motion was seconded and carried.)

Report of the Council on Medical Education and Hospitals

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the By-laws, which reads in part:

". Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Medical Education and Hospitals is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each committee report.*
3. *Recommendations by the KMA Board of Trustees on the over-all contents at the conclusion of the report.*

The Council on Medical Education and Hospitals has met twice during the Associational year, June 21 and May 13. At its first meeting the members of the Council discussed the activities of the committees serving under the Council and reviewed the duties of each. The committees serving under the Council are: Advisory Committee to the University of Kentucky, Advisory Committee to the University of Louisville, AMA-ERF Committee, General Practice Committee and Hospital Committee.

Also at its first meeting, the Council (1) reviewed pertinent matters that had been approved by the House of Delegates of the American Medical Association at the December Clinical Meeting of the AMA, (2) reviewed an Interim Report on the evaluation of the Questionnaire on Medical Education distributed to all KMA members in June 1964 and (3) recommended that the monies in the Postgraduate Medical Education Fund Account be returned to the KMA General Fund Account. This recommendation was approved by the Board of Trustees on March 17 and subsequently implemented by the Council.

In making the above recommendation, members of the Council pointed out that there was no specific need for use of funds in the Postgraduate Office at the present time since the function of the office was one of coordination while the medical schools, KAGP, specialty groups and other organizations were actually providing the postgraduate opportunities. A small amount of funds is being maintained in the Postgraduate Account to insure the tax exempt status should reactivation of the account be desired in the future.

The main items discussed at the second meeting of the Council were (1) a thorough evaluation of the Questionnaire on Medical Education, (2) the report of the committees serving under the Council and (3) selection of the 1965 Faculty Scientific Achievement Award recipients.

The Council members felt that the thirty-one page report evaluating the Questionnaire on Medical Education was of such interest that it should be included in the House of Delegates Handbook. The Council recommended that the Board of Trustees, at their meeting to consider this report, authorize the printing and distribution of ample copies of this report for inclusion in the KMA House of Delegates Handbook and for distribution to the state's two medical schools. A member of this Council has also been asked to present an editorial and short article on the questionnaire to the editor of the KMA Journal for publication.

The report of the committees covering their activities and recommendations follows:

Recommendations, Reference Committee No. 2

This report was studied and testimony was heard on the report as a whole and on the reports of the committees under this Council.

Attention is called to page two, paragraph two in which an Addendum Report was made deleting this action because it had been determined that to transfer these funds would jeopardize the tax exempt status of the Postgraduate Office and the Board of Trustees had directed that this be returned to the Postgraduate Account.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Advisory Committee to the University of Louisville

George A. Sehlinger, M.D., Louisville, Chairman

and

Advisory Committee to the University of Kentucky

Andrew M. Moore, M.D., Lexington, Chairman

The Advisory Committee to the University of Louisville School of Medicine and the University of Kentucky College of Medicine met jointly during this Associational year on April 22, 1965.

Committee members briefly reviewed reports to the 1964 House of Delegates and committee duties and concentrated their attention on the medical questionnaire which was developed by the Council on Medical Education and Hospitals to study and improve the "Town and Gown" relationship.

The questionnaire, sent to the state's approximately 2,700 physicians, of which 720 (27%) replied was designed to elicit basic identifying information about the physicians own medical education; and the location and type of his practice; his current affiliation with a medical school; his familiarity with and opinions concerning medical educators and research; his familiarity with, current use, potential future use and opinions concerning postgraduate education; his opinions concerning relationships between medical school faculty members and practicing physicians.

After thoroughly reviewing the report, the committee members noted that most comments centered around 4 basic categories: namely communication, postgraduate education, research, and general practice. A summary of the comments made on these subjects was felt to be of such interest as to be incorporated in this report.

I. Communication:

A. That even though there already exists good relationship between the medical schools and the profession in the communities, there is no reason for complacency and actually there is a need to improve communications.

B. Continual use of the KMA Journal page and other publications afford the medical schools an opportunity to present pertinent information to the physicians throughout the state.

C. We again urge participation of more full-time faculty members in the affairs of the county medical society and in organized medicine.

II. Postgraduate Education:

A. The committee members were impressed with the high percentage of physicians taking advantage of postgraduate opportunities offered and felt that the medical schools are probably doing more in the field of postgraduate education programs than is recognized.

B. The findings of this survey were very favorable for the continuation of these postgraduate medical education programs and it would seem to indicate that further expansion of these programs be given consideration.

C. We urge the utilization of the voluntary faculty in the postgraduate programs of the medical schools.

III. Research:

A. With reference to research, the committee members feel that the practicing physicians need a better understanding of the fact that the medical schools have a multitude of areas in which to fulfill their obligations.

B. It is the committees' feeling that research does not detract from the teaching of students, but gives the students an opportunity to enter the research program. Research is essential in medical school progress and elimination of research is ill-advised.

C. Research enriches educational opportunities and finances on a national average, 51% of the cost of medical schools.

IV. General Practice:

It was pointed out that it is AMA and KMA policy to encourage general practice and that general practice programs are now being explored at the University of Kentucky and the University of Louisville. Also, the AMA has an Ad Hoc Committee on Family Practice and a Commission of Graduate Medical Education which are taking a new look into this area. Some fundamental recommendations may come from these groups within the next year or two.

The members of these committees wish to thank the 720 physicians who replied to the questionnaire and to Robert Straus, Ph.D., and Clare W. Winslow, Department of Behavioral Science, University of Kentucky Medical Center, for preparing the report and analyzing the results.

COUNCIL ACTION: It is recommended by the Council on Medical Education and Hospitals that the Joint Report of the Advisory Committee to the University of Louisville and the Advisory Committee to the University of Kentucky be accepted as presented. The members of this Council feel that it has been very beneficial for these committees to have met jointly and urges the Committees to meet jointly in the future.

Recommendations, Reference Committee No. 2

This report was studied and this reference committee wishes to reiterate the council's appreciation to Doctor Robert Straus of the University of Kentucky College of Medicine for compiling the statistics gleaned from the questionnaire sent out to the entire membership. Your attention is called to this report which is included in your folders as an addendum.

The reference committee felt that an important step in improving the efficiency of these committees was made in their having met jointly and concurs with the council recommendation that they continue to do so in the future.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

AMA-ERF Committee

Walter I. Hume, Jr., M.D., Louisville, Chairman

The AMA-ERF Committee of the Kentucky Medical Association found no need to call a meeting of the committee this year. The purpose of this committee is to promote contributions to the American Medical Association Education and Research Foundation through which funds are designated for research, unrestricted use by medical schools, and loans to medical students, interns, and residents. This past year, your committee has informed the KMA membership of AMA-ERF programs and promoted contributions to the fund by means of the KMA Communicator and the Journal of KMA. Quarterly mailings are distributed to all AMA members from the American Medical Association.

Allocations of the 1964 AMA-ERF contributions to Kentucky medical schools amounted to $15,244.88. A check in the amount of $4,359.57 was presented to the dean of the University of Kentucky College of Medicine on April 13, and on April 19, the dean of the University of Louisville School of Medicine received $10,905.27. In making the presentations, KMA officials pointed out that this was a portion of the $1,313,559.31 contributed to the fund during 1964; an increase of $110,000 over 1963. Since 1951, more than $15,000,000 has been distributed from this source to medical schools.

Under the loan portion of the program, 186 loans were made to Kentucky students, interns, and residents last year amounting to $218,600.

Your committee members would like to take this opportunity to express appreciation to the physicians of Kentucky and the Woman's Auxiliary for their support of the AMA-ERF.

Recommendations, Reference Committee No. 2

This report was studied and felt that there was merit in the suggestion made from the floor that the Advisory Committees to the medical schools and this committee study the needs of the students in our two medical schools with the hope that some recommendations for more efficient utilization of these contributions might be made.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

General Practice Committee

E. C. Seeley, M.D., London, Chairman

The General Practice Committee met at the Kentucky Hotel in Louisville on Thursday, May 6.

We considered the questionnaire circulated by the 1964 committee and the members were acquainted with the statistics. No additional action was recommended concerning this questionnaire.

There was a rather lengthy discussion concerning the shortage of general practitioners in this country and in Kentucky, in particular.

It was noted that currently only 25% of all the physicians in America are now engaged in general practice. However, this 25% provides 65% of the care of general practice type illness which constitutes 85% of all out-of-hospital physician-patient contacts. This, of course, leaves 35% of general practice being done by non-general practitioners.

In view of these facts and in as much as everyone realized the need for more general practitioners, and since the mechanics have been set in motion for the certification of family practitioners, this committee recommends that KMA go on record in favor of and utilize whatever means available to influence the medical schools in this state to establish departments of general practice or family practice. These, however, are not to be confused with the departments of public health or community medicine.

The report of the Council on Medical Education of the AMA concerning the utilization of ambulatory patients in an internship was considered and received as information.

The committee was brought up to date on the proceedings of the 1965 American Academy of General Practice Congress of Delegates.

The AMA Resolution #34 having to do with General Practitioners meeting the medical needs of the American public was considered, discussed, and received for information.

There was considerable discussion as to the need of statistical information concerning the distribution of physicians in Kentucky as to type of practice. It is therefore a further recommendation of this committee that a survey be made of all physicians in the state of Kentucky to determine their type of practice, whether it be general practice or a specialty. This should be facilitated in any way that the KMA thinks is most feasible.

As chairman of the General Practice Committee, I would like to express my appreciation to the members of the committee for participating this past year.

Recommendations, Reference Committee No. 2

The report was studied and testimony was heard relative to it and the committee concurs on the council's recommendation that the report be accepted.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Hospital Committee

James B. Holloway, M. D., Lexington, Chairman

The Hospital Committee has met once this year February 11, 1965. A second meeting is scheduled for May 20, and because the Council on Medical Education and Hospitals is scheduled to meet on May 13, a report of this May 20 meeting will be added as an addendum to this final report.

The committee heard a report from Mr. Harry Jobe, Administrator, King's Daughters' Hospital, Frankfort, that the Hospital Association had received a number of complaints on emergency rooms. Following a discussion, it was taken by common consent that the Hospital Committee recommend to the Board of Trustees through the Council on Medical Education and Hospitals that the committee be authorized to work with the Hospital Association to publish a pamphlet on emergency rooms that could be purchased by those hospitals desiring to distribute it.

The committee discussed the problem of completing medical records properly and suggested clinics might be held for insufficiently trained medical record librarians. It was suggested that perhaps Blue Cross, the Health Insurance Council, KHA, and the KMA contribute financially toward the visit of a trained medical record librarian to those hospitals that need help in this area. It was pointed out that the Hospital Committee has no funds for this purpose and a recommendation would have to be made to the KMA Board of Trustees to receive authorization for such an expenditure. This is to be further discussed in next meeting.

William McBeath, M.D., of the State Department of Health, outlined the Hill-Burton program since its inception and reported that Kentucky's application requests have increased each year, but the state would be allocated only 3.7 million dollars for general hospital beds. Doctor McBeath also reported that the recently passed Hill-Harris amendment to the Hill-Burton act changed the provision of the State Advisory Council composition from 12 members to 20, with an equal number of representatives being consumers.

During the discussion on hospital planning, it was suggested that the KMA and KHA might approach the Kentucky Chamber of Commerce and try to get the support of the lay population in organizing area-wide hospital planning on a state level. It was taken by common consent that the Hospital Committee recommends through the Council on Medical Education and Hospitals to the Board of Trustees that the Kentucky Medical Association take the lead in forming a voluntary area-wide Hospital Planning Commission for Kentucky, and that KMA and KHA be represented on the Commission in the minority.

The chairman reported that the "dry-run" teams had made two visits since last year's Annual Meeting (Adair Memorial Hospital in Columbia, and the Methodist Hospital in Henderson), and each hospital visited was very appreciative. Any recognized hospital can request a visit of the "dry-run" team for the purpose of preparing for an accreditation visit from the Joint Commission on the Accreditation of Hospitals or for the purpose of up-grading hospital standards without any planned accreditation visit. Guidelines for the "dry-run" team members and for hospitals requesting "dry-runs" have been prepared for distribution through the cooperation of the Kentucky Medical Association, Kentucky Hospital Association, and the Kentucky State Association of medical Record Librarians.

The chairman also reported to the committee the latest developments pertaining to the ARHI Hospitals

and said he felt there was a big improvement made during the last year, and that time appeared to be the major factor in the solution of the problem.

COUNCIL ACTION: It is recommended by the Council on Medical Education and Hospitals that the report as submitted be accepted, but that the recommendation presented concerning the development of additional training of Medical Record Librarians be expanded to include endorsement of the establishment of educational programs for Medical Record Librarians in the community colleges or in appropriate health related programs of the universities. The members of the Council feel that the financial participation of KMA is not indicated in this particular activity.

COUNCIL ON MEDICAL EDUCATION AND HOSPITALS
George A. Sehlinger, M.D., Louisville, Chairman
James B. Holloway, M.D., Lexington
Walter I. Hume, Jr., M.D., Louisville
Andrew M. Moore, M.D., Lexington
E. C. Seeley, M.D., London
Donn L. Smith, M.D., Louisville
William R. Willard, M.D., Lexington

Addendum to Report of The Hospital Committee

The Hospital Committee met on May 20, 1965 at the KMA Headquarters office and the following actions were taken by the committee:

1. The Hospital Committee received a report from the Pike County Medical Society relative to a tuberculosis "survey" being run by the Public Health Service through three Appalachia Regional Hospitals. The Hospital Committee goes on record that this is not a satisfactory survey as it does not include all the hospitals in the community and that perhaps it would be an attempt to channel federal funds into the Appalachia Regional Hospitals. We wish to call this to the attention of the Council on Medical Education and Hospitals and the Board of Trustees.

2. The Hospital Committee is pleased to report that arrangements have been made for hospitals which wish medical record librarians to come in as consultants to their medical records and to train a medical record librarian. To do so, it would cost $35 per day plus expenses. This will be circulated through the Kentucky Hospital Association and the Journal of KMA. Expenses are to be paid by the Hospitals requesting help. The medical record librarian visiting the local hospital is prepared to meet with the medical staff and to outline adequate medical procedures.

3. Progress was not made on the emergency room pamphlet because the Kentucky Hospital Association had been unable by this date to acquire sufficient literature. This will be a subject for discussion in September.

4. The committee decided the "dry-run" teams would only inspect those hospitals which had never been accredited or which had lost their accreditation.

5. A lengthy discussion was given to the setting up of a state-wide area-wide planning group for medical facilities. The committee as a whole feels that the state Association should take the lead in this area. The individual members appreciate the immense difficulies involved and the great areas for friction in vested interests. During the summer, literature will be collected from successful area planning groups and preliminary discussion will be undertaken with Blue Cross-Blue Shield, Kentucky Chamber of Commerce, and the state government. More concepts and definite recommendations will be made following a meeting of the Hospital Committee on September 9, prior to the state meeting.

Report of the Council on Medical Services

[Page 3, first full paragraph and last paragraph on page 21

Members of the Council reviewed other committee and council actions to include the questionnaire on Medical Education and the recommendation of the Hospital Committee concerning the formation of a voluntary area-wide hospital planning commission for Kentucky. Your Council on Medical Services strongly endorses this recommendation of the Hospital Committee and urges its approval.

The AMA had adopted a policy urging physicians to participate in Voluntary Area-Wide Planning for Hospitals and Health Related Facilities. We are pleased that some County Medical Societies in Kentucky have already formed Area-Wide Hospital Committees and as mentioned above a recommendation has been made urging that KMA take the lead in forming such a committee on a state wide basis.

Recommendations, Reference Committee No. 2

This report and an addendum prepared after the last meeting of the Council was considered. The reference committee concurs in the Council's action relative to paragraph one, page eight, "that financial participation by KMA is not indicated in this particular activity."

The substance of paragraph three, page eight and paragraph two and paragraph four, page two of the report of the Council on Medical Services (Report #14) were essentially the same and these three paragraphs were considered together and the reference committee was in agreement with these recommendations calling attention to the fact that the committee recommends that if an area-wide hospital planning commission for Kentucky be formed that it be on a voluntary basis. In the addendum to the report of the hospital committee, paragraph numbered one, the committee feels that special emphasis should be placed upon this portion of the report feeling that the members of KMA should be alert to such attempts to create inaccurate statistics through inadequate sampling surveys such as this. The reference committee wishes to amend paragraph numbered two on the same page by adding the word "record" before the last work in the paragraph causing it to read as follows: "The medical record librarian visiting the local hospital is prepared to meet with the medical staff and to outline adequate medical record proceedings".

It was felt that this resulted from a typographical error to begin with.

Mr. Speaker, I move the adoption of this section of the report, as amended. (Motion was seconded and carried.)

Resolution C
Jessamine County Medical Society

WHEREAS, there is a definite shortage of doctors in many areas of our state and

WHEREAS, this shortage is primarily in the small towns and rural areas where only good general practitioners of medicine can meet the needs of the people and

WHEREAS, in recent years the trend toward specialization in medical practice has increased thus concentrating great numbers of doctors in the population centers and medical centers and in turn depleting the number of doctors available in the small towns and

WHEREAS, most of our medical schools in years past have not encouraged students to enter general practice and in some cases have even discouraged this action and

WHEREAS, various plans of a half-hearted nature have been temporarily adopted in several large hos-

pitals and teaching centers over the country to provide better training for those who would enter general practice and

WHEREAS, most of these plans for better general practice training have failed because they were on paper only and were not actually sanctioned by the majority of the department heads of the educational center and in other cases were not given financial support by the institution and

WHEREAS the University of Kentucky has some very fine plans for the training of good general practitioners of medicine, plans that have been published in a prominent medical journal, GP, and many educators and critics have discussed and given general approval to this plan, department heads at that School have given their sanction, and financial support is being arranged and

WHEREAS, some individuals at the U. K. Medical Center have exerted much time in surveying the past efforts, degree of success or failure and factors involved in numerous situations in many different institutions in this country and now has presented what appears to be a practical and workable plan for the effective training of good general practitioners.

THEREFORE BE IT RESOLVED that this body go on record to commend the U. K. Medical Center for interest in this problem, the vigorous efforts in study and approval of a plan to alleviate the great need for good general practitioners of medicine in our state.

Recommendations, Reference Committee No. 2

This resolution was considered and the committee recommends its adoption.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Mr. Speaker, I move the adoption and implementation of this report as a whole. (The motion was seconded and carried.)

As chairman I would like to express my appreciation to the members of my committee for conscientious and diligent work and also to those who appeared before the committee to give testimony.

Reference Committee no. 2

E. C. Seeley, M.D., London, Chairman
Eugene H. Conner, M.D., Louisville
W. B. Haley, M.D., Paducah
Paul J. Parks, M.D., Bowling Green
J. Sankey Williams, M.D., Nicholasville

REFERENCE COMMITTEE NO. 3†

Richard F. Greathouse, M.D., Chairman

Reports on Legislative Activities

†See Note (†) bottom of column 1, page 972.

Reports considered by this committee were:

Resolution D—Oath Not to Discriminate

Resolution I—Formal Compliance to Title VI of the Civil Rights Act of 1964

Resolution E—State Bond Issue

13. Report of the Council on Legislative Activities

Resolution F—Legal and Ethical Implications of Participation and Non-Participation in Public Law 89-97

Resolution H—Resolution from the Jefferson County Medical Society on the Resolution from the Council on Legislative Activities, as submitted to the House in Report No. 13

Resolution L—Socialized Medicine

16. Report of the Council on Allied Professions and Related Groups, page 23 (2) and the Addendum.
16. Report of the Council on Allied Professions and Related Groups, page 13, IV. Silver Nitrate Prophylaxis in the Eyes of Premature Newborn Infants.
15. Report of the Council on Communications and Public Service, page 17, (7)—Good Samaritan Legislation, plus Board of Trustees action.
14. Report of the Council on Medical Services, page 4 (2) and p. 5, (4), and *COUNCIL ACTION.*

Resolution D

Daviess County Medical Society

At a special called meeting of the Daviess County Medical Society held at 6:30 P.M., September 14, 1965, the following resolution was proposed and approved by those present:

WHEREAS, the members of the Daviess County Medical Society have not in the past discriminated in their practice,

THEREFORE BE IT RESOLVED, that any order that physicians of Daviess County sign an oath not to discriminate be considered presumptuous and an insult to the physicians of Daviess County.

Resolution I

Trimble County Delegation

WHEREAS: There has been an indication and official information from the Federal Department of Health, Education, and Welfare concerning practices prohibited by Title VI of the Civil Rights Act of 1964, and

WHEREAS: Several States and their Departments of Public Welfare along with the Kentucky State Department of Health have indicated to physicians that they will be required to sign a written compliance not to discriminate among patients who are welfare recipients, and

WHEREAS: Any written requirement to a physician concerning patients he is required to treat would be a violation of basic professional integrity and medical motivation, and

WHEREAS: It is the official position of the Kentucky Medical Association that the principles of medical ethics more than cover the question concerning discrimination,

THEREFORE BE IT RESOLVED, that the physicians of Kentucky go on record as officially opposed to signing any formal statement concerning their treatment of patients.

DOW-113
(7-65)

STATEMENT OF COMPLIANCE PURSUANT TO TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

(Name and address of vendor)

does not on the ground of race, color, or national origin:

a. deny any individual any aid, care, services, or other benefits provided under the program;
b. provide any aid, care, services, or other benefits to an individual which is different, or is provided in a different manner, from that provided to others under the program;
c. subject an individual to segregation or separate treatment in any matter related to his receipt of any aid, care, services, or other benefits provided under the program;
d. restrict an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any aid, care, services, or other benefits provided under the program;
e. treat an individual differently from others in determining whether he satisfies any eligibility or other requirement or condition which individuals must meet in order to receive any aid, care, services, or other benefits provided under the program;

f. deny any individual an opportunity to participate in the program through the provision of services or otherwise or afford him an opportunity to do so which is different from that afforded others under the program.

Official authorized to sign

Title

Date

Recommendations, Reference Committee No. 3

This Reference Committee endorses the sentiment of Resolutions D and I, and furthermore, would like to recommend that the House authorize the Board of Trustees to furnish legal assistance to any doctor, who, in good conscience, feels that he cannot sign the Statement of Compliance (copy of which is appended), and who wishes to test its legality in the courts.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Resolution E

Fayette County Medical Society

WHEREAS, the 1965 Bond Issue in the November 4, 1965, election is a partisan political issue,

THEREFORE BE IT RESOLVED, that the House of Delegates of the Kentucky Medical Association vote neither to endorse nor reject the proposed Bond Issue.

Recommendations, Reference Committee No. 3

In full recognition of the fact that the Board of Trustees have already endorsed the State Bond Issue, the Committee recommends that the Resolution not pass; however, this was an issue that was not going to be voted on until November, and it was known that the House of Delegates was going to meet in September; therefore, the matter could have been submitted to the House of Delegates for a decision.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Council on Legislative Activities

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the Bylaws, which reads in part:

" . . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Legislative Activities is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Recommendations by the KMA Board of Trustees on the overall contents at the conclusion of the report.*

The Council has met four times in regular session during the past year. One productive and stimulating session being held in Washington, D.C. at the time of the Congressional Dinner. At this time the Council recommended to the Chairman of the Board (and subsequently helped arrange details) a special called session of the KMA House of Delegates and all KMA legislative key men in Owensboro on March 17th. To this observer, the meeting was quite worthwhile; a sense of unity and singleness of purpose was felt to be noted that has not previously existed to this degree.

On The National Level, We Have Occupied Ourselves Chiefly With The Matter Of Most Immediate Concern To All Of Us—HR 6675. Although there are other bills of equally devastating import, the accent from the Administration has forced us to face this issue as the matter of primary importance. Because, at the time of this writing, this legislation has not entirely jelled, we will postpone further analysis of the bill for a supplemental report.

Suffice it to be said that there seems a good chance for passage of the parts of the bill that are most abhorrent to us as free practicing physicians.

The parts most unacceptable to us directly are:

1. THE USE OF THE SOCIAL SECURITY MECHANISM AS AN OSTENSIBLY RESPECTABLE VEHICLE FOR THE SOCIALIZATION OF MEDICINE.

The rich as well as the less rich stand to receive federally paid hospitalization that they have not contributed to. The true intent of its proponents was clearly demonstrated when immediately after House passage of HR 6675, there were demands for it to be made more all inclusive. The editorial comment by the Courier-Journal was to the effect "this is still a far cry from the 'enlightened' medical care enjoyed by the countries of Europe." Apparently "enlightened" can be interpreted as "socialized"—yet this statement follows several years of editorial reassurances by this newspaper that they do not approve of socialized medicine and that King-Anderson type legislation does not carry such a threat for the citizens and for the profession.

2. THE FORCED INCLUSION OF PHYSICIANS UNDER THE SOCIAL SECURITY RETIREMENT PROGRAM.

The chief of the Social Security Program has only recently stated in an interview for US News and World Report that a self-employed person could buy better retirement and disability insurance from a private plan for the same money.

3. THE "GUTS" OF THIS LAW, IF PASSED, WILL CONSIST OF ARBITRARY REGULATIONS MADE BY THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE.

This implies tremendous possibilities of one-man intimidation of our profession. He knows he must depend on us for successful implementation of the program.

Although, in the opinion of the chairman, we must not let our reaction to bad legislation rebound to the detriment of our patients, the Congress is certainly ill advised if it believes we will accept this challenge to our ability and integrity and the future of medicine, in good spirits.

We owe debts of gratitude to six of our nine men in Congress who have not only given us sympathetic audience, but have gone the last mile in the Houses of Congress in voting against this legislation. We especially appreciate the amendment offered by Senator Morton that would have served to remove the physician from compulsory participation in the Social Security "Insurance Program". He also voted against the Bill when it was on the floor of the Senate, despite certain knowledge that the Bill would pass.

S 596. At the time this report is written, the chairman is preparing to return to Washington to gather information and discuss with our legislators the merits of the Bill resulting from the "DeBakey Report" to the President concerning means of controlling the "killer diseases: heart, cancer and stroke". The raison

d'etre for this bill is obscure to the writer and to most of those who will be charged with its implementation. In essence, the bill would expand the scope of medical centers to the smaller communities where a "specialist" would be in charge of a branch of a medical school to act as a czar over the medical care of persons stricken with these diseases—or "any other disease found by the Surgeon General to be of major significance".

In the words of Irvin E. Hendryson, M.D., chairman of the AMA Committee on Medical Facilities, "Medicare is peanuts compared to the potential of this proposal" . . . "Let's not kid ourselves; these complexes could involve the Federal Government in health care for the entire population". We are in hearty agreement with this analysis.

Many, or most, of the medical school deans, into whose hands the implementation of this bill would fall, have little idea as to what use they could make of this measure, against these widely publicized diseases, despite the 1.3 billion dollars that may be thrown to them along with its passage.

Although most of our time has been spent on the two pieces of legislation already discussed, we have kept abreast of the numerous other legislative developments that effect medicine and have taken action where appropriate.

The Washington dinner was held as directed by the Board of Trustees and was considered by those in attendence to have contributed significantly to our relationship with our Congressmen. There were 22 physicians and their wives in attendance—most of them visited with their own congressman, their senators and other legislators with whom they felt it advisable to do so. An "official" group visited all the offices of the Congressmen who were in Washington that day—we held sessions with the staff of those who were out of town for various reasons.

It is hard to overestimate the value of this function in maintaining a working relationship with our friends in Washington.

We are sorry to report that G. L. Simpson, M.D., Greenville, has felt it necessary to resign his position as legislative key man for the First Congressional District. His unselfish contributions to the Association in the past number of years are now legend and although his leadership is badly needed, and will continue to be for many years, we are in sympathy with his desire to slacken the pace and are working at selecting a replacement.

The Legislative Bulletin has been published and distributed regularly during this year. This is a valuable publication that we recommend for the basis of discussion at Society meetings.

For the past several months, we have had the pleasure of working with Mr. Gil Armstrong, who has replaced Mr. Ken Young as field service representative. We have found him to be diligent, informed, and interested, and congratulate Mr. Joe Sanford on having selected this valuable addition to his fine staff.

State Affairs

James C. Cantrill, M.D., Chairman

The first meeting of the Council was held November 18, 1964. At this time, recommendations for congressional district key men to the Board of Trustees were made. There was a discussion on KMA's interest in the recently formed committee to set up a new State of Kentucky Constitution, the Association's concern being in the Coroner's system.

A report was heard from the special Ad Hoc Committee on Cults. Interest was also expressed in the operation of the new Hill-Burton program, as amended by the 88th Congress, and what influence it would have in Kentucky.

The second meeting of the Council was held January 13, 1965. One of the matters decided at this time was our participation in the KMA Interim Meeting program to be held in Owensboro the 18th of March. The Interim Meeting Committee had asked our Council to provide the afternoon program. It was agreed that both the chairman for national affairs and the chairman for state affairs would take part in this second most important meeting.

There was a discussion of possible proposals by some of the allied groups to be introduced into the 1966 Legislature for the upgrading of their profession. Additional consideration was given to the work of the Kentucky Constitutional Revision Committee, and the upgrading of our medical examiner system.

Doctor Quertermous presented a proposed draft, designed to delineate the responsibility of the key man system. While all agreed that from a mechanical point of view, it was quite well done, members of the Council felt that the effectiveness of the booklet would be enhanced if the duties and responsibilities of the individual key man were clearly defined. It was decided that the personnel of the key man system should be revised following the general election in November of this year.

Your chairman for State Affairs attended in January a conference, sponsored by the AMA on the operation of the Kerr-Mills Program. This proved to be a very stimulating and profitable experience.

On February 15 and 16, we were part of a delegation of some twenty-odd KMA members and wives who visited our congressmen and senators in Washington and attended the annual KMA dinner the night of the 16th, honoring Kentucky's senators and congressmen.

At the April 28 meeting, the Council gave consideration to possible bills that would be introduced into the State Legislature. These included proposed measures from the State Department of Health, upgrading the Nurse Practice Act, and proposals relating to the Sewer Construction and Sanitation Districts. Malcolm Barnes, M.D., regarded as one of the top authorities on the Medical Examiner System, appeared before the Council to discuss recommendations to the Kentucky Constitutional Revision Committee. The Council also considered recommendations on what the Association's position would be on reapportionment of the legislative and congressional districts, if a special session were called. (A special session has been called, but we are not advised if the reapportionment issue will be included in this call or in a subsequent call.)

In order to indoctrinate the physicians of our state in legislative procedures and responsibilities, the Council passed a recommendation to the House of Delegates through the Board of Trustees as follows: That each county assume the responsibility of sending one or more physicians to the legislature at least one day during the regular session of the legislature, starting in January to call on their respective representatives and senators and to observe the operation of the legislature. The Council on Legislative Activities will assume the responsibility for scheduling each county.

The Council gave careful consideration to revising the Key Man Booklet, changing the nomenclature, and making this handy reference for legislative key men more effective. This will be perfected in subsequent meetings of the Council.

Your Council also gave further consideration to the upgrading of the Nurse Practice Act. It gave consideration to medical licensure, possible recommendations to changing the laws of animal research and the formulation of a legislative program. In due course, the Council will make, as provided by the bylaws of KMA, specific recommendations to

the Board of Trustees on all of these legislative proposals when they are introduced and recommend policy.

The Council had instructed our KMA lobbyist, G. L. Armstrong, to attend a special session of the legislature should it be called. Since one has been called, Mr. Armstrong will be in attendance. The Council heard the report of its Sub-committee on Cults and will no doubt have a recommendation to the Board on this matter later.

The Council reaffirms its belief in the objectives of KEMPAC and AMPAC and recommends one hundred per cent participation by doctors and their wives. We also recommend to the House of Delegates that there be county society billing in order to encourage this participation, and we finally recommend a vote of endorsement and encouragement by this House of Delegates of the KEMPAC organization to continue its worthwhile political efforts in the behalf of our free enterprise system and the freedom of the art and science of medicine.

The Council will meet one or more times prior to the meeting of the House of Delegates and will probably have an addendum to this report.

The medical profession in Kentucky is becoming cognizant of its responsibility to carry out the mandate in Article II of the KMA Constitution, which reads ". . . the enactment and enforcement of just medical laws . . ." This not only obligates the profession to pass good laws, but it makes us equally responsible in resisting legislative proposals that are not in the public interest. It has also become increasingly evident that our legislators are becoming more aware of our interest in doing a better job for the public in this area.

To properly discharge our responsibility in this field, we must first of all know who our local senator and representative are. We should make their acquaintances and demonstrate our interest in good government to them prior to the time they go to Frankfort.

Next, we must be appropriately informed on the issues. Our KMA Legislative Key Man Bulletin is intended to provide our key men with this information. Each county has a key man whose responsibility it is to serve the members of that county and provide this information.

Finally, when the legislature is in session, make sure that you follow developments closely. Maintain reasonably frequent contacts with your senator or representative. This can be done personally, by letter, or on the phone.

We should remember that most legislators are just as eager to serve the public as physicians are, and that they are interested in knowing how we feel and why. We should remember that each legislator must not only listen to us, but all other groups, and we must recognize that he will not always make his decision on issues in a way that will be totally satisfactory to the profession.

There is every reason to believe that the 1966 Kentucky General Assembly will see a record number of items introduced involving the public interest in the health field. Some of these will be good; others will be designed to serve selfish purposes. Our responsibility in this legislature will be tremendous.

With this in mind, we would recommend to the House of Delegates that it request the Board of Trustees to use every available resource of the Association in whatever way it deems best to make the membership of KMA aware of its responsibility in this area, and to discharge it in a manner that will be in keeping with the traditional professional desire to render to our patients the best possible service.

Finally, we would like to express appreciation for the fine work that G. L. Simpson, M.D., Greenville, has done during the past two years as the first congressional district key man. We regret that Doctor Simpson has found it necessary to resign because of other demands on his time.

COUNCIL ON LEGISLATIVE ACTIVITIES
Branham B. Baughman, M.D., Frankfort
Hoyt D. Gardner, M.D., Louisville
Daryl P. Harvey, M.D., Glasgow
Gabe A. Payne, Jr., M.D., Hopkinsville
David B. Stevens, M.D., Lexington
John C. Quertermous, M.D., Murray
Chairman—National Affairs
James C. Cantrill, M.D., Georgetown
Chairman—State Affairs

Addendum to the Report of the Council on Legislative Activities

(The following Resolution was approved by the Council on Legislative Activities at its meeting on August 25, 1965, for consideration by the House of Delegates. This action was taken after the Annual Report to the 1965 House of Delegates had been sent through the Board of Trustees, in the manner provided for under Chapter VIII, Section 4, paragraph 4.)

WHEREAS, regulations are about to be designed that will determine the effect of Public Law 89-97 on the medical community and the people of the United States, and

WHEREAS, the AMA, after an audience with the President, has been invited to participate in drawing up these regulations, and

WHEREAS, a law of such import would have an overwhelming effect on the private practice of medicine, if implemented without the benefit of the wisdom of doctors active in the private practice of medicine, as expressed thru their organization, and

WHEREAS, there is some conflict among the physicians as to whether to participate or not to participate in Public Law 89-97, and

WHEREAS, it is the opinion of the AMA legal counsel that concerted non-participation may be a violation of the Sherman Anti-Trust Act, and

WHEREAS, non-participation is at this time a poorly defined premise, and

WHEREAS, each physican has the privilege by law to decide for himself whether he will participate in this program and indeed, has the duty not to participate in any program that will render his care to his patients less effective,

THEREFORE, BE IT RESOLVED, that we will adhere to Section VI of the principles of medical ethics of the American Medical Association, which states . . . "that a physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause deterioration of the quality of medical care", and as implied in the time-honored Hippocratic oath, and

BE IT FURTHER RESOLVED, that we encourage the AMA Task Force in Medicare to be active in drawing up the regulations that will determine the complexion of Public Law 89-97, and any subsequent laws of a similar nature, so that the physician-patient relationship will not be compromised, and

BE IT FURTHER RESOLVED, that we will actively engage in a role of leadership in designing laws to improve the health of our people of the United States, and

BE IT FURTHER RESOLVED, that KMA will support physicians, acting alone or as a group thru their medical organizations, to freely criticize Public Law 89-97, and to seek its repeal or modification.

COUNCIL ON LEGISLATIVE ACTIVITIES
Hoyt D. Gardner, M.D., Louisville
Gabe A. Payne, Jr., M.D., Hopkinsville
David B. Stevens, M.D., Lexington
John C. Quertermous,M.D.,Murray, Chairman, National Affairs
James C. Cantrill,M.D., Georgetown, Chairman, State Affairs
Branham B. Baughman, M.D., Frankfort, was not able to be present at this meeting.

Minority Report

The undersigned, a member of the Council on Legislative Activities, not agreeing with the Council's Resolution, and having voted against same at the Council meeting at which it was presented and passed, almost at the conclusion of the last meeting of the Council, after a long day's work; and there being insufficient time at said meeting to adequately and judiciously prepare for Council's consideration a meaningful Substitute Resolution; and that being the last meeting of the Council prior to the mailing of the Delegates' kits, respectfully submits the attached Substitute Resolution as a Minority Report of the Council on Legislative Activities, because the undersigned does not believe the scope and tenor of the Council's Resolution to be sufficiently broad to include all major medical programs.

The undersigned believes that the Council's Resolution poses questions that may be divisive and not in the best interest of medicine at this time.

Daryl P. Harvey,M.D., Glasgow,Member, KMA Council on Legislative Activities

Resolution

Regarding Augmentation of K.M.A. Policy on all Major Medical Programs

WHEREAS, there are vital matters facing Medicine today that should be given prompt, necessary, and judicious consideration; and

WHEREAS, the true strength of Medicine is the physician. His profound concern and wishes in Kentucky are reflected, defined, and directed by you—the House of Delegates of KMA; and

WHEREAS, medical legislation which is contrary to our established policies and principles has been enacted. This legislation is now being executed and implemented. Such action raises several questions as to the role of both the individual physician and organized medical groups;

THEREFORE, BE IT RESOLVED, that KMA's present and future role in the meeting of all medical programs shall be specific. We suggest and request the following harmonious guidelines:

A. KMA shall voluntarily give advice, guidance, and publicity to only those third-party medical programs which are legal and in keeping with moral and ethical standards of KMA.

B. KMA shall use its strength and facilities to advise and educate all individual physicians and recognized medical groups as to what is legal and in keeping with KMA's moral and ethical standards.

(KMA shall likewise support, defend, and protect the members of KMA and medical groups whose actions and programs are legal and in concert with the moral and ethical standards of KMA).

BE IT FURTHER RESOLVED, that KMA shall, by all legal means, continue to strive to criticize and eliminate any and all medical programs or policies which are illegal or in conflict with the moral and ethical standards of KMA.

BE IT FINALLY RESOLVED, that the House of Delegates of KMA urge all individual physicians, and especially the leaders of our National, State, and County Societies, to face the present and future with calm equanimity.

Daryl P. Harvey, M.D., Glasgow, Member, KMA Council on Legislative Activities

Resolution F

Todd County Medical Society

WHEREAS, there is much unrest and distrust among the membership of KMA concerning Public Law 8997, and

WHEREAS, the leadership of the AMA has, through a designated task force, met with the President of the United States of America and the Secretary and officers of the Department of Health, Education, and Welfare, offering assistance in formulating the regulations and implementation of the law, and

WHEREAS, to many, such activity denotes tacit approval of the law by the AMA and creates further distrust among many of the members, and

WHEREAS, the members need to know the exact interpretation of the law by the legal counsels of both the KMA and the AMA in order to assist them in making up their minds whether to participate or not to participate without being in danger or fear of prosecution by the government or censored by the associations, *Now Therefore Be It*

RESOLVED, that the members of the KMA be informed as soon as possible whether or not any member, upon his own volition, has the right as a citizen to participate or not to participate in implementing or carrying out the law without being prosecuted or censored, *And Be It Further*

RESOLVED that if such information is available, let it become known to this House of Delegates at this Annual Meeting.

Resolution H

Jefferson County Medical Society

WHEREAS: A special called meeting of the American Medical Association House of Delegates has been set for October 2-3 in Chicago, Illinois, to discuss the implications of Public Law 89-97 for the medical profession, and

WHEREAS: The Resolution by the KMA Council on Legislative Activities as stated in Report No. 13 is premature at this time, therefore

BE IT RESOLVED, that the Resolutions from the Lesislative Council as Submitted in Report No. 13 be tabled by the House of Delegates, and

BE IT FURTHER RESOLVED, that any action of KMA concerning participation in Public Law 89-97 be deferred to the Board of Trustees who may call a special session of this House of Delegates, based on any information received from the AMA meeting, when and if the need is apparent.

Recommendations, Reference Committee No. 3

This Reference Committee recognized John C. Quertermous, M.D., Murray, James C. Cantrill, M.D., Georgetown, and Daryl P. Harvey, M.D., of Glasgow, of the Council on Legislative Activities, and Hollis Johnson, M.D., representing the Jefferson County Medical Society, as the author of Resolution H, who asked permission to withdraw these resolutions, and requested that this Reference Committee formulate a Statement of Policy for the House to act upon. Resolution F was also read before the Committee, and duly considered, along with the other resolutions.

It is the recommendation of this Reference Committee that the following Resolution regarding augmentation of KMA policy on all medical programs be adopted:

WHEREAS, there are vital matters facing Medicine today that should be given prompt, necessary, and judicious consideration; and,

WHEREAS, the true strength of Medicine is the physician. His profound concern and wishes for his patients and his moral and ethical standards in Kentucky are reflected, defined, and directed by you—the House of Delegates of KMA; and

WHEREAS, medical legislation which is contrary to our established policies and principles has been enacted. This legislation is now being executed and implemented. Such action raises several questions as to the role of both the individual physician and organized medicine; and

WHEREAS, KMA's present and future role in dealing with all medical programs should be definite, specific, and firm in principle, but allow for diversity of action.

THEREFORE, BE IT RESOLVED, that KMA shall voluntarily give advice, guidance, and assistance to only those medical programs which are in keeping with the moral and ethical standards of KMA; and

BE IT FURTHER RESOLVED that KMA shall use its strength and facilities to advise and educate all individual physicians and recognized medical groups as to what is in keeping with KMA's moral and ethical standards; and

BE IT FURTHER RESOLVED that KMA shall likewise support, defend, and protect the principles and programs of KMA and recognized medical groups, whose actions and programs are in concert with the moral and ethical standards of KMA; and

BE IT FURTHER RESOLVED that KMA shall, by all legal means, continue to criticize and strive to eliminate any and all medical programs or policies which are in conflict with the moral and ethical standards of KMA; and

BE IT FURTHER RESOLVED, that KMA delegates to the AMA be and are instructed to present the foregoing Resolution, which embodies the policy of KMA, to the House of Delegates of AMA for their consideration and adoption as a basic policy of AMA.

BE IT FINALLY RESOLVED, that the House of delegates of KMA urge all individual physicians, and especially the leaders of our National, State, and County Societies, to face the present and future with poise and composure.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded.)

Lengthy discussion was held on this portion of the reference committee report. Irving Kanner, M.D., Fayette County, moved to amend the resolution by striking out the words beginning "that KMA shall voluntarily give advice," through this paragraph and down through "Be it Further Resolved". There was a second to the amendment.

After the tellers had completed the count, the Speaker stated that the amendment carried.

(The amended resolution then read as follows:)

WHEREAS, there are vital matters facing Medicine today that should be given prompt, necessary, and judicious consideration; and,

WHEREAS, the true strength of Medicine is the physician. His profound concern and wishes for his patients and his moral and ethical standards in Kentucky are reflected, defined, and directed by you—the House of Delegates of KMA; and

WHEREAS, medical legislation which is contrary to our established policies and principles has been enacted. This legislation is now being executed and implemented. Such action raises several questions as to the role of both the individual physician and organized medicine; and

WHEREAS, KMA's present and future role in dealing with all medical programs should be definite, specific, and firm in principle, but allow for diversity of action.

THEREFORE BE IT RESOLVED that KMA shall use its strength and facilities to advise and educate all individual physicians and recognized medical groups as to what is in keeping with KMA's moral and ethical standards; and

BE IT FURTHER RESOLVED that KMA shall likewise support, defend, and protect the principles and programs of KMA and recognized medical groups, whose actions and programs are in concert with the moral and ethical standards of KMA; and

BE IT FURTHER RESOLVED that KMA shall, by all legal means, continue to criticize and strive to eliminate any and all medical programs or policies which are in conflict with the moral and ethical standards of KMA; and

BE IT FURTHER RESOLVED that KMA delegates to the AMA be and are instructed to present the foregoing Resolution, which embodies the policy of KMA, to the House of Delegates of AMA for their consideration and adoption as a basic policy of AMA.

BE IT FINALLY RESOLVED, that the House of Delegates of KMA urge all individual physicians, and especially the leaders of our National, State and County Societies, to face the present and future with poise and composure.

Gabe A. Payne, M.D., Christian County, moved to amend the reference committee report by deleting on page two of that part of the report beginning with the second paragraph, "It is the recommendation of this committee" . . . and ending with the last word on page three which is "composure". There was a second to the amendment. Following a ten minute recess of the House, Doctor Payne with the consent of his seconder, withdrew his motion to amend.

The Speaker stated that the question had been called for. There was a motion and a second to move the previous question, and it carried.

The motion on the reference committee report as amended was defeated.

Irving Kanner, M.D., Fayette County, submitted the following resolution from the Fayette County Medical Society:

WHEREAS, there is a meeting of the AMA in October of 1965.

THEREFORE BE IT RESOLVED, that the KMA recommend to the AMA that every effort be made to find a solution within the present law that would be morally and ethically acceptable to the members of this association, and that should such efforts fail in the opinion of the Board of Trustees of KMA, that there be an immediate called meeting of the House of Delegates to discuss such failure. There was a second to the resolution. The resolution was defeated.

Carl Fortune, M.D., Fayette County, moved to discuss Resolution L. (The motion was seconded and carried.)

Resolution L

Pulaski County Medical Society

WHEREAS, Medicare is socialized medicine with medical care controlled by government and paid for by taxes.

WHEREAS, there is ample proof that in every country where socialized medicine has been imposed upon the people that the patients suffer from deterioration of medical care and physicians find themselves against a wall of hindrance and interference with red tape.

WHEREAS, a selected group of physicians narrowly escaped from becoming completely involved in the present medicare program.

WHEREAS, Compulsory participation is not the law of the land. Therefore non-participation is not a violation of the law.

WHEREAS, Only physicians can socialize and regiment themselves because only physicians are

capable of practicing medicare. There is no justification for physicians to become involved in bad medical care which is concocted by the Great Society, which cannot deliver the medical care they are promising.

BE IT RESOLVED, that if physicians are to keep faith with the Hippocratic Oath with section 6 of the Principles of Medical Ethics of the AMA, and with the Bauer Non-Participation Resolution adopted in 1961 by the AMA, they have no course to pursue other than the employment of non-participation in medicare.

FURTHER, for a physician to do otherwise than non-participate would be a shameful retreat from the medical profession's position of opposing socialized medical care. It would be a disgraceful attempt at compromising principles. Efforts by any physician to make the evil law work would constitute a flagrant display of timidity, weakness, and acquiescence to an unethical and immoral program.

Recommendations, Reference Committee No. 3

The Committee considered Resolution L, and being advised by the Association's legal counsel that a concerted program of non-participation would invite prosecution under the Anti-Trust Laws, recommends that said Resolution not pass.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded.)

(During the discussion of Resolution L, the speaker stated that the counsel for the state medical association had pointed out that in his opinion concerted action on the part of the House not to participate is in violation, or could well be in violation, of the anti-trust laws.)

George P. Archer, M.D., Floyd County, offered the following amendment:

Before the KMA decides whether to participate or not participate, that the KMA petition the Governor of Kentucky that he request our advice, guidance and assistance to all medical programs originating in Frankfort and/or being handed down from Washington for implementation on the state, county or local level, and that the Governor be informed that the KMA stands ready and willing to offer this assistance at his discretion. Therefore, after the program (or programs) have been evolved, then we shall decide each on its own merits according to the policy and medical code of ethics of the AMA and KMA.

The amendment was seconded. Following further discussion, Doctor Archer and the seconder of his amendment agreed to delete "Before the KMA decides whether to participate or not participate . . ." and substitute "Before each individual member of KMA decides whether to participate or not to participate . . ."

Doctor Archer with the consent of the seconder of his amendment withdrew the amendment.

The question was asked for and seconded. The motion carried.

The recommendation of the reference committee concerning resolution L was adopted.

Doctor Archer then re-submitted his resolution which read:

"Before each individual member of KMA decides whether to participate or not to participate, that the KMA petition the Governor of Kentucky that he request our advice, guidance and assistance to all medical programs originating in Frankfort and/or being handed down from Washington for implementation on the state, county or local level, and that the Governor be informed that the KMA stands ready and willing to offer this assistance at his discretion. Therefore, after the program (or programs) have been evolved, then we shall decide each on its own merits according to the policy and medical code of ethics of the AMA and KMA."

The question was called for and seconded. The motion carried.

Doctor Archer's resolution was then put to a vote and adopted.

Council on Allied Professions and Related Groups

Page 23, (2) and the Addendum—Statement of W. K. Massie, M.D., of Lexington, Kentucky, before the Committee on Finance, United States Senate, regarding HR 6675 and the Workmen's Compensation Law.

2) Approve, if acceptable, the statement of the legal committee of the Kentucky Bar Association relative to the disability status of workers unable to return to their original occupation, or, in lieu of this, formulate suggested legislation for consideration by the 1966 House of Legislature relative to the above subjects.

STATEMENT OF W. K. MASSIE, M.D. OF LEXINGTON, KENTUCKY

Re: HR 6675, Social Security Amendments of 1965

Before the Committee on Finance
United States Senate

May 12, 1965

Mr. Chairman and Members of the Committee:

I am Dr. W. K. Massie, an orthopoedic surgeon from Lexington, Kentucky, and am appearing here today in my capacity as Chairman of the Kentucky Medical Rehabilitation Committee. I would like to confine my remarks, however, to Section 303, Title 3, at page 176 (Disability Insurance Benefits).

As a rehabilitation committee, we have been concerned with all factors which enhance or retard the return of a disabled worker to a gainful occupation. Rehabilitation which does not terminate in reemployment is futile and all funds thus expended wasted. We must, therefore, scrutinize carefully any proposed legislation which might have the effect of negating such rehabilitation.

To date, social security is available *only* to permanently totally disabled workers. Under Section 303, HR 6675, such payments could be made to workers temporarily or permanently totally disabled for six consecutive months. The objective of the section appears to be the provision of speedier benefits for the temporarily or permanently disabled worker whether or not covered by workmen's compensation benefits. This admittedly increases tremendously the expenditure from the Disability Trust Fund, but with this we are not concerned. The effect which these regular payments (often simultaneously with workmen's compensation payments) have on the incentive of a worker to cooperate fully with a provided rehabilitation service is certainly a negative one. Should it serve to convert even a small percentage of temporarily disabled workers into permanently disabled ones by stimulating their resistance to rehabilitation, its deleterious effects, it seems, would outweigh its advantages. Rehabilitation is as often influenced by socio-economic factors as physical ones. Just as no physical fitness program can alter the conditioning of the populace without individual participation of its members, elaborate outlays for rehabilitation will not increase the work tolerance of a single apathetic worker.

The effect of Section 303 would be most devastating in just those low income, frequently single-industry areas. Such areas provide little choice to the patient but to return to his original occupation. To return a heavy laborer with a temporarily disabling backache to his job requires the active cooperation of the worker and often the employer. Rehabilitation rarely restores the work tolerance to the pre-injury level. Usually the worker must return to work on a temporarily partial disability basis which

is rapidly converted to unrestricted activity by participation in a familiar labor. If the work is scarce and the workers many, is there much pressure on an employer to rehire a temporarily disabled worker when he knows the worker is well cared for under a program other than workmen's compensation?

Social security disability benefits, unlike many welfare programs, are administered on an "all or none" basis—either the worker is totally disabled or he is not covered. This has a paralyzing effect on rehabilitation cooperation since the worker will not return to work on a temporary partial disability status.

Finally, the full force of discouragement is brought to bear on the worker with the best prognosis for full recovery. Unlike the worker disabled by psychoneurosis or cardiovascular disease, the worker injured on the job and covered by workmen's compensation is more likely to be restored to full capacity or left with a minor permanent impairment compatible with his original work. However, encouraged by dual compensation, he may be recalcitrant to all rehabilitation efforts.

If the objective, then, is to return a worker to active work status in the shortest possible time, recognizing this to be the optimum mental and physical therapy, then we would request that the committee give serious attention to Section 303. We believe it should be deleted in its entirety, since its deleterious effects seem to outweigh its advantages. If it should only be modified, certainly we would hope that it will be amended to preclude the payment of dual compensation.

We appreciate the opportunity to express our views before this committee.

Recommendations, Reference Committee No. 3

Doctor Massie appeared before the Committee and presented a summation of his Amendment to Report No. 16, regarding the Kentucky Workmen's Compensation Law.

This Reference Committee recommends that the Association endorse the concept of rehabilitation as a part of Workmen's Compensation and authorize the Council on Legislative Activities to cooperate with the State Bar Association and others in securing an amendment to the Workmen's Compensation Law, which would implement the recommendation of the Council on Allied Professions and Related Groups in this regard.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried)

Council on Allied Professions and Related Groups

page 13, IV

IV. Silver Nitrate Prophylaxis in the Eyes of Premature Newborn Infants, was brought up for discussion and the consensus of opinion of the entire committee was that we should recommend to the council on Allied Professions and Related Groups that it recommend to the Kentucky State Medical Association again that an attempt be made to change the old State Statute, requirning silver nitrate administration to premature newborn infants in the state of Kentucky. The committee felt that in view of the newer antibiotic eye ointment available, i.e., Achromycin Ointment and Erythromycin Ointment as well as others, that many of the chemical conjunctivitis reactions from silver nitrate were no longer necessary. The committee felt strongly that some prophylaxis in the eye should be continued, particularly in view of the rising incidence of venereal disease in the state. However, it seems to us that many of the untoward reactions which occur in such a high percentage of cases with the silver nitrate prophylaxis could be eliminated if the discretion of what prophylaxis to be used were to be left to the discretion of the individual physician in attendance. We strongly urge that this matter be given due consideration and steps taken to amend the statute through proper legislative procedures.

Statement of American Academy of Pediatrics
(State Chairman)
September 21, 1965

The Kentucky Chapter of the American Academy of Pediatrics recommends to the Board of Trustees of the KMA that the present law, which requires eye prophylaxis and allows the State Board of Health to decide which drug to use in neonates, be maintained until further study is done.

Robert McLeod, M.D.
Acting State Chairman
AMERICAN ACADEMY OF PEDIATRICS

Recommendations, Reference Committee No. 3

This Reference Committee recommends disapproval of the recommendation of the Council on Allied Professions and Related Groups until further study of the problem can be made.

The Kentucky Chapter of the American Academy of Pediatrics having met and recommended to the Board of Trustees of the Kentucky Medical Association that the present law, which requires eye prophylaxis in neonates, be maintained until further study is done.

Mr. Speaker, I move the adoption of this section of this section of the report. (Motion seconded; carried.)

Report of the Council on Communications and Public Service

page 17 (7)

7. The committee has further investigated the need for Good Samaritan Legislation and it is our recommendation that a planning committee be appointed to prepare appropriate and acceptable Good Samaritan Legislation

BOARD ACTION: Accepted as amended. The Board approved the request of the Senior Day Committee to allocate $500 annually in their budget for the purpose of securing guest speakers and recommend that paragraph 7 on page 17 of the Disaster Medical Care Committee referring to good samaritan legislation be disapproved.

Recommendations, Reference Committee No. 3

The Reference Committee considered the recommendation of the Council on Communications and Public Service, that a planning committee be appointed to prepare appropriate and acceptable Good Samaritan Legislation, and being advised by the Association's legal counsel that the Constitution of Kentucky prohibits legislation which would relieve any person from responsibility for his own negligence, recommends that this suggestion *not* be adopted.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Council on Medical Services

page 4, (2) and page 5, (4), and Council Action

2. The KMA insist that the Kentucky Legislature pass legislation which would make the Kentucky Department of Health the administering agency of any Medical Assistance to the Aged Program, rather than joint administration by the Department of Health and the Department of Economic Security, since this is a Health Program and not a Welfare Program.

The KMA also strongly advise and recommend

that the Blue Cross and Blue Shield Plans, Inc., of Kentucky, of any acceptable qualified and approved insurance carrier licensed in the state, be appointed as Fiscal Intermediary for any Medical Assistance to the Aged Program.

4. The KMA members refuse to participate in any Medical Care Program for the Aged in any way after 1/1/66, unless the heretofore mentioned recommendations are implemented in an acceptable manner.

COUNCIL ACTION: It is recommended that the report of the Committee on Aging be accepted with the following amendments. The Council recommends the following introductory phrase be added at the beginning of *Recommendation Number 1.* "In the event that any Federal or State Medical Assistance to the Aged Program imposes a fixed fee for services rendered by physicians," the KMA etc. The Council further recommends that *Recommendation Number* 4 be ommitted from the report.

Recommendations, Reference Committee No. 3

It must be reported that there was and is considerable discontent with the MAA program, as now administered, and some action should be taken to implement the new program in an acceptable manner. Also, considerable testimony was heard in opposition to any form of a fixed fee schedule.

The Reference Committee considered this subject thoroughly, hearing lengthy evidence, both pro and con. The points brought up by the Committee on Aging of the Council on Medical Services were well taken.

However, the strong opposition from many members present at this Committee hearing reflects the wide divergence of opinion now within the Kentucky Medical Association. We do not feel that a discussion or debate on the floor of the House at this time would produce a satisfactory conclusion of this question. The feeling of many members may be altered by subsequent legislation and by the action of the American Medical Association's House of Delegates in October.

We, therefore, recommend that the Board of Trustees, at its discretion, convene a Special Session of this House of Delegates, after the AMA meeting, to further consider this matter.

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion seconded and carried.)

Mr. Speaker, I move the adoption and implementation of this report as amended.

James E. Ferrell, M.D., Bourbon County, moved an amendment that this report be referred to the Board of Trustees for consideration because of the confusion that has surrounded the entire discussion and the importance of the one main section of this report. The amendment was seconded.

The legal counsel clarified the amendment by stating that the House had adopted each section or had taken action on each section of the report. The effect of the amendment would be rather than to adopt as a whole and file it in the usual manner that each of these actions be referred to the Board of Trustees for such action as the Board in its discretion deems desirable. The effect of it would not be to undo everything that has been done but to leave it flexible to where the Board of Trustees could do with it as the Board in its discretion feels desirable. Doctor Ferrell stated that this was the intent of his amendment. (The motion on the amendment carried.)

The vote on the original motion carried that the report be accepted as amended.

As chairman, I wish to thank Doctors Oldham, Stevens, Stevie, and Thomas for their patient attendance during a five-hour session of this Reference Committee.

REFERENCE COMMITTEE NO. 3
Richard F. Greathouse, M.D., Louisville, Chairman
J. S. Oldham, M.D., Owensboro
David B. Stevens, M.D., Lexington
J. R. Stevie, M.D., Covington
Ralph G. Thomas, M.D., Leitchfield

REFERENCE COMMITTEE NO. 4†

Andrew M. Moore, M.D., Chairman

Reports on Public Service and Allied Professions

†*See note (†) bottom of column 1, page 972.*

The reports this reference committee considered are as follows:

15. Report of the Council on Communications and Public Service to the 1965 Session of the House of Delegates (with the exception of Paragraph 2, page 15, referred to Committee No. 1)
16. Report of the Council on Allied Professions and Related Groups to the 1965 Session of the House of Delegates (With the exception of Section IV, page 13, Perinatal Mortality and Morbidity Study Committee, and Page 14, Section VI, Perinatal Mortality and Morbidity Study Committee. The first referred to Committee No. 3 and the second referred to Committee No. 1. Page 23, Section 2, Physical Medicine and Rehabilitation, referred to Committee No. 3 with statement of W. K. Massie, M.D., regarding HR 6675.)
14. Report of the Council on Medical Services, Page 12, Paragraph 2, pertaining to the New Orientation Program of the Kentucky Medical Association.

Resolution J — Voluntary State-Wide Testing for early Detection of PKU

Report of the Council on Communications and Public Service

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the Bylaws, which reads in part:

> *". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."*

The material in this report of the Council on Communications and Public Service is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each committee report.*
3. *Recommendations by the KMA Board of Trustees on the overall contents at the conclusion of the report.*

The Council on Communications and Public Service has called two meetings during this Associational year on December 14, 1964 and July 8, 1965.

At its first meeting, the Council accepted reports from the chairmen of the committees serving under the Council and discussed future plans of the committees.

It was felt that it would be desirable for KMA to participate in the teletype communications system with the AMA and other state associations, and we are happy to report that teletype equipment was installed in the KMA Headquarters Office early in 1965 at no expense to our association.

The Council had received a request for KMA to present a certificate to the winner of a county science fair. Approval was granted by the Board of Trustees for such a certificate and a sample certificate has been forwarded to the Board for final approval.

Members of the Council wish to report that exhibits displayed by the Association this year have been received enthusiastically, particularly the 1965 KEA exhibit dealing with materials available to health teachers and vocational guidance counselors. Over 2,500 pamphlets were mailed on request to interested KEA members. An exhibit on quackery will appear at the 1965 State Fair and will be manned by KMA staff. The exhibit presented at the KEA meeting will also be presented at the Annual Meeting of the Kentucky Medical Association. Exhibits have been approved for the 1966 State Fair and KEA meeting.

We would like to bring to the attention of the House of Delegates that the Third Annual Community Health Week will be held November 7-13. The KMA Public Health Committee will be responsible for its promotion.

It may be interesting to note that the Council is continuing its policy of distributing information to students throughout the state on various health topics to include careers and makes available physicians and KMA staff members for speeches on special topics to schools and other selected groups. This past year "Medicare" was the subject of debate teams throughout the state. We provided information kits on this subject to numerous students and also provided background material for students writing papers and giving classroom presentations on health subjects. The Council also promoted an AMA Foods and Nutrition Lecture Series in five Kentucky colleges by writing news releases and letters to County Medical Societies.

The ten committees serving under the Council are Diabetes, Disaster Medical Care, Highway Safety, Medicine and Religion, Orientation, Public Health, Rural Health, School Health, Senior Day and Advisory to Woman's Auxiliary. The following final reports of the Committees are herewith submitted:

Recommendations, Reference Committee No. 4

The report of the Council on Communications and Public Service was studied in detail. It was quite obvious to the Committee that the Council had been extremely active during the last year and its Committees were constantly probing new avenues. The activities of the Committees of this Council are extremely important. Their adequate implementation at the county level is necessary for successful completion. It was brought out in discussion that in many areas of this state, county societies are small and, because of this, they are severely handicapped in arming some of the proposals. It is the opinion of this Reference Committee that the Board of Trustees could well consider some method of combining the efforts of adjacent small county societies to improve their effectiveness and, yet not lose their identity.

Mr. Speaker, I move the acceptance of this section of the report and the recommendation. (Motion was seconded and carried.)

Diabetes Committee

Irving F. Kanner, M.D., Lexington, Chairman

Your Diabetes Committee met once during the Association year, March 31, and had as its guests Carlisle Morse, M.D., Louisville and Mr. Omar Greeman, of the Chronic Disease Control Program, State Department of Health.

Noting that the 15th annual Diabetes Detection and Education Week will be held this year during the week of November 14-20, it was recommended that a similar promotional program be conducted for this drive as in previous years.

Your Committee would like to take this opportunity to express its appreciation to all the local county medical society diabetes chairmen, all KMA members, allied groups and cooperating organizations that enabled us to establish new records in the number of tests reported and number diagnosed as new diabetics. This 14th annual drive, sponsored by the KMA in cooperation with the American Diabetes Association, saw 103,248 free tests made and 230 proved cases reported.

Since the first date in 1951, more than 2,000 previously unknown diabetics have been found. There is no doubt that this drive is one of our outstanding public service programs. As we continue to get greater participation, future drives will be more successful than this past year.

Mr. Greeman reported that the State Department of Health wants to cooperate with the Diabetes Committee in every way possible. He said the Chronic Disease Department has put in for funds to buy an auto-analyzer for use in testing blood sugars and suggested the Diabetes Committee recommend the use of this piece of equipment by county societies. It was taken by common consent that the Committee recommend to the Board of Trustees through the Council on Communications and Public Service that the KMA approve the use of auto-analyzers or other blood sugar tests in the Diabetes Detection Drive whenever county societies feel this to be feasible.

Your chairman wishes to thank those members for their efforts in making this such a successful year and for serving on this KMA committee.

Recommendations, Reference Committee No. 4

Mr. Speaker, I move the acceptance of this section of the report and the recommendation. (Motion was seconded and carried.)

Highway Safety Committee

John J. Robbins, M.D., Louisville, Chairman

A variety of items considered to be of vital interest to our committee, were discussed at the Highway Safety Meeting on January 28, 1965. The following is a brief synopsis of those topics and the recommendations made.

1. The committee discussed the seat belt laws of various states and the fact that Kentucky has none. It was recommended that we request permission from the KMA Board of Trustees, through the Council on Communications and Public Service that this committee be authorized to write a letter to the Governor's Highway Safety Action Committee indicating our support in desiring to see mandatory seat belt legislation introduced in the next session of the state legislature. It is further recommended that this letter include the following two matters:
 (a) That we recommend that the State Government take the same action as the Federal Government in listing safety devices to be included on all cars purchased by the State Government. The safety devices to be listed are those recommended to the General Services Administration by the American Association of Automotive Medicine.
 (b) That we inform the Action Committee that KMA is in favor of compulsory annual automobile inspection.

2. It was reported that the Automobile Crash Injury Research Program (Cornell) was in its third year and that the sixth and final phase would end in July, 1965. It was taken by common consent

that this committee recommend to the Board of Trustees, through the Council on Communications and Public Service that a letter be sent to ACIR Headquarters at Cornell University stating that should it desire to extend the ACIR Program in Kentucky for an additional year, the Kentucky Medical Association offers its support and cooperation.

Your committee is interested in furthering the joint relationship of medicine and law toward the approach of manufacturers uniformly building a safer vehicle and has expressed itself in this regard by letter to the President of the Kentucky Bar Association. It was pointed out that the Kentucky Bar Association had approved such action, but that it had not gotten through the American Bar Association committee. It was felt that this should be pushed up to the American Bar level and ultimately get a conjoint effort of the AMA and the American Bar Association to put more pressure on the manufacturer.

Your chairman has written to Henry Harned, executive secretary of the Kentucky Bar Association, to ask if they have an active committee and if so, who are its members. A letter also was sent to the Louisville Bar Association inquiring about the possibility of a conjoint impetus from the Vehicle Safety Committee of that Association.

We wish to call to the attention of the membership of KMA that Kentucky is one of the five states having a driver limitation program and that its program has received national attention. Other states have adopted the driver limitation principles which have been approved in the Kentucky program. The success of this program is due in part to the physicians cooperating in submitting their reports to the Medical Review Board. Over 500 cases have come before the Medical Review Board to date. Only four drivers have been suspended, while many have been restricted.

Since the Automotive Safety Awards presentation first started, seven companies or organizations have received certificates for seat belts installed in 100% of their cars. It is felt that the seat belt award should receive more publicity through an article in the KMA Communicator and additional coverage in the newspapers at the time an award is given. It is hoped the article in the Communicator would result in physicians making announcements about the availability of this award to civic groups and other organizations in their communities thereby getting more county medical societies and other organizations in Kentucky to apply for this award.

Your committee wishes to express appreciation to Arthur Keeney, M.D., for the outstanding leadership he has given the Highway Safety Committee during the term he served as chairman and to the other members of the committee for their effective contributions.

Recommendations, Reference Committee No. 4

Highway Safety Committee. It was noted that in Section B, under Part 1 of this report, that due to probable typographical error, the word "Governor's" should be inserted before the words, "Action Committee". This Committee's activities are extremely important for the general well-being.

Mr. Speaker, I move this section of the report as corrected be adopted and its recommendation be implemented. (Motion seconded; carried.)

Medicine and Religion Committee

Joseph H. Saunders, M.D., Lexington, Chairman

The following represents a summary in the field of medicine and religion as reported to this committee. Major activities have centered in the Sixth Trustee District and in Fayette County. In the 1964-65 period the committee from the Warren, Butler, and Edmonson County Society has met on four occasions with the committee of the ministerial association in the area. The meetings included one to organize, one to "Pre-Marital Counseling," and another on the film, "The One Who Heals." A hospital administrator was the speaker at the fourth meeting, discussing briefly visitation by clergy, etc. It was stated that these committees, made up of six physicians and six ministers, are trying to disseminate information regarding the work of the medicine and religion committee. The feeling was expressed that in the Warren County area the men representing the ministerial association seem to be quite interested in the program.

On April 29 a committee meeting was held in Fayette County with the physicians and representatives of the major faiths in attendance. A digest of this meeting was incorporated in the digest of the Committee on Medicine and Religion, which was held at the Headquarters Office of the KMA on June 16, 1965. Richard McElvein, M.D., was elected as chairman of the Fayette County committee. As soon as the committee is built up in knowledge and strength, it hopes to sponsor a joint meeting of the physicians and clergy of Fayette County.

On April 29, 1965, there was an inaugural convocation at the University of Kentucky Medical Center on pastoral care and education. This meeting stressed the Medical Center's recognition that a school of comprehensive patient care necessitates adequate provisions for meeting the spiritual needs of patients.

On July 13, 1965 the Sixth Trustee District Medical Society will hold a medicine and religion meeting with Mr. Arne Larson from the AMA as speaker. Each member of the society is asked to bring his minister to the dinner meeting.

The committee will have an AMA exhibit at the KMA Annual Meeting, staffed by members of the committee. A tape recorder will be used to interview individual doctors at the booth for the three days of the meeting.

The chairman will submit an article for the August or September Journal to publicize the activities of this committee.

The Committee on Medicine and Religion recommends to the Board of Trustees through the Council on Communications and Public Service that a medicine and religion chairman be appointed for each trustee district beginning with the 1965-66 year.

A breakfast meeting of this committee will be held on Wednesday, September 22, 1965, during the KMA Annual Meeting.

Recommendations, Reference Committee No. 4

This Committee is developing industriously a new idea which has many obvious benefits.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Orientation Committee

N. Lewis Bosworth, M.D., Lexington, Chairman

There was one meeting held by the Orientation Committee on April 1, 1965. The Orientation Program has been approved by the House of Delegates and implementation has been authorized. The plans of this committee in presenting the Orientation course have been approved by the Executive Committee of the KMA Board of Trustees.

A policy has been established that all new KMA members accepted on or after January 1, 1965 are required to take the orientation course in accordance with Section 5 Chapter I of the KMA Bylaws.

All new members applying after January 1, 1965 will occupy a provisional status until they have completed one of the orientation courses and such will be noted on their membership card.

Three letters are to be sent to each new member, the first to be sent out immediately following re-

ceipt of the new member's dues. The second letter will be mailed about six weeks prior to the Orientation course and the third letter will be sent out three weeks in advance of the program. In addition, the program will be published in the KMA Journal, promoted through the Communicator and will appear in the Annual Meeting Program.

The first Orientation course has been authorized by the House of Delegates and will be presented on Monday, September 20 preceeding the 1965 KMA Annual Meeting. The second course will be held in conjunction with the 1966 Interim Meeting and the exact date will be announced.

Much time and consideration was given to the structure of the program and a definite format was decided upon including the time schedule and the speakers. The response of the speakers has been gratifying. The committee expresses sincere appreciation to those men that have agreed to participate on this program.

Recommendations, Reference Committee No. 4

It was noted by the Reference Committee that the Orientation Program has been implemented and on the occasion of this first course, the attendance was approximately 51 per cent. Within the Reference Committee, discussion developed regarding the worthwhile objectives of the Orientation program. It was felt that consideration should be given by the Board of Trustees to the possible advantages of making attendance at the annual Kentucky Medical Association meeting every several years compulsory in order to continue orientation of our present members with the aims and purposes of the Association. (Motion seconded; carried)

Public Health Committee

Ralph D. Lynn, M.D., Elkton, Chairman

The activities of the year centered around the Immunization Week program; however, other actions and recommendations were decided on at the committee's meeting on March 11, 1965.

It was the consensus of opinion that Immunization week proves to be very effective in stimulating parents and guardians to immunize children before one year of age. Although the members of the committee felt that immunization of diphtheria, tetanus, pertussis and polio is a year-round project, they also felt that an immunization program against measles should be started. The committee members agreed to discuss this at future meetings.

In approving the promotional material for the immunization program, which was held from May 2-8 by proclamation of Governor Edward T. Breathitt, the members also added measles in conjunction with the other diseases on the promotion poster.

Committee members noted that a great number of rabid animals are running loose in Kentucky, especially dogs, and a good dog-control program should be started, therefore, the committee recommends KMA approval of the following resolution on rabies:

WHEREAS, exposure to rabies, be it more fancied than real, poses a constant danger in many Kentucky communities today, and

WHEREAS, annually in Kentucky, hundreds of people are needlessly subjected to the discomfort, risks, and expense involved in the "taking" of 14 anti-rabies shots, and

WHEREAS, sensitiveness to public opinion has brought about laxity on the part of local elected officials in carrying out the provisions of state laws for dog control, and

WHEREAS, in the past two years, the State Department of Health has suffered a cut in funds for general public health programs causing necessitated curtailment of several programs, including rabies control, and

WHEREAS, public information and leadership is sorely needed regarding rabies control laws, therefore be it

RESOLVED, that the House of Delegates of the Kentucky Medical Association go on record as recommending county medical societies, in the interest of the profession, as well as the public, play an active role in leading its community to develop an adequate dog-control program.

Recommendations, Reference Committee No. 4

Public Health Committee. It was noted by the Reference Committee on Page 10 that the second WHEREAS which states:

"*WHEREAS*, annually in Kentucky, hundreds of people are needlessly subjected to the discomfort, risks, and expense involved in the "taking" of 14 anti-rabies shots, and"

should be changed to read as follows:

"*WHEREAS*, annually in Kentucky, hundreds of people are needlessly subjected to the discomfort, risks, and expense involved in the administration and receiving anti-rabies therapy, and"

which would express the same thought in more suitable language.

Further, considering the fourth WHEREAS which states:

"*WHEREAS*, in the past two years, the State Department of Health has suffered a cut in funds for general public health programs causing necessitated curtailment of several programs, including rabies control, and"

should be improved by changing it to read:

"*WHEREAS*, in the past two years, the State Department of Health has suffered a cut in funds for general public health programs, and"

Mr. Speaker, I move the adoption of this section, as corrected, of the report. (Motion seconded; carried.)

(The amended resolution now reads:

WHEREAS, exposure to rabies, be it more fancied than real, poses a constant danger in many Kentucky communities today, and

WHEREAS, annually in Kentucky, hundreds of people are needlessly subjected to the discomfort, risks, and expense involved in the administration and receiving anti-rabies therapy, and

WHEREAS, sensitiveness to public opinion has brought about laxity on the part of local elected officials in carrying out the provisions of state laws for dog control, and

WHEREAS, in the past two years, the State Department of Health has suffered a cut in funds for general public health programs, and

WHEREAS, public information and leadership is sorely needed regarding rabies control laws, therefore be it

RESOLVED, that the House of Delegates of the Kentucky Medical Association go on record as recommending county medical societies, in the interest of the profession, as well as the public, play an active role in leading its community to develop an adequate dog-control program.)

Rural Health Committee

Donald L. Graves, M.D., Frenchburg, Chairman

Three members of the KMA, Gaithel L. Simpson, M.D., Joseph Hamburg, M.D., and Donald L. Graves, M.D., attended the 18th National Rural Health Conference in Miami on March 26 and 27. Doctor Simpson was a participant on a panel of four doctors who discussed the practical implications of health care programs and primarily the Kerr-Mills program. One part of the Conference, on public service, emphasized that public service time on radio and television is available for use by physicians. It was the suggestion of the Rural Health Committee to give consideration to using these public service facilities.

This committee has been vitally interested in health

careers and had asked Doctor Hamburg to check the availability of funds to finance a survey of the state to determine para-medical requirements. In checking with Doctor Teague and others, it was found that there will be no state funds available this year. Other large funds that sponsor this type of program indicated that these funds have been allocated and they are not entering any new program.

The Department of Community Medicine at the University of Kentucky is making a study of Martin County. This began as a tuberculosis eradication project and has developed into a general health study of the area. Kurt W. Deuschle, M.D., chairman of the department of community medicine at the University of Kentucky, has stated that he would be very happy to have the KMA cooperate in the program. We would then have access to the results, which would include how the need relates to the number of physicians, types of physicians, etc.

This committee recommends that the Kentucky Medical Association support this program and authorize the chairman of the Rural Health Committee to write a letter to this group endorsing its activities and stating that we will be willing to cooperate in any way.

The committee discussed the shortage of nurses over the state and recommended that the next KMA-KNA Joint Advisory Committee meeting this problem of shortage be discussed.

A proposal for a new Rural Health Council brochure was approved. It was suggested that as an added source of distribution, a supply be given to the county health offices and membership of the Rural Health Council. It was recommended that the Medical Assistants Association be added to the list of invited guests to the Rural Health Conference.

The 1965 Kentucky Rural Health Conference will be held on October 21 at Hopkinsville. A number of committee meetings have already been held, and the general program outline is being developed. The program this year will follow the same pattern as that of the 1963 Conference at Jenny Wiley State Park. The subject this year will be "A Profile of Health Service Resources and Unmet Needs in Western Kentucky.

COUNCIL ACTION: It is recommended that the report of the Rural Health Committee be accepted as presented with the exception of the recommendation concerning a general health study in Martin County. The Council withheld action on this recommendation due to inadequate information.

Recommendations, Reference Committee No. 4

The activities of this Committee were studied. The suggestion of greater utilization of public service time on radio and television is commended and the availability of such time in the opinion of the Reference Committee should be passed on to other committees and councils and the use of this public service time be encouraged. It was noted that Council withheld judgment due to lack of information regarding Paragraph 1 on page 11 (beginning with the words, "The Department of Community Medicine at the University of Kentucky" . . .) as there was no information available other than mentioned. It was the opinion of the Reference Committee that this matter be referred to the Rural Health Committee for further study and information. (Motion seconded; carried.)

School Health Committee

O. B. Murphy, M.D., Lexington, Chairman

The importance of a better physical education program in the state's school system dominated the discussion at our committee meeting on June 17, 1965.

Although there is such a program in existance at the present, it is the feeling of the committee there is room for great improvement. The chairman of the committee is to meet with Mr. Harry Sparks, superintendent of Public Instruction, to seek an improved program. The chairman recalled the committee had received authority from KMA to work toward a stronger program of physical education. The committee members were in agreement that there should be a superintendent of Physical Education just as a superintendent of Instruction and their activities should be directed in making this position a reality.

Mr. Don Bale, assistant superintendent of Public Instruction for the Commonwealth of Kentucky, was invited to our meeting to give a report on the state-wide physical fitness program in Kentucky schools, but was unable to attend. He sent in a report which said the State Department of Education, in cooperation with the Governor's Council on Physical Fitness, is sponsoring a pilot program for the 7th and 8th grade pupils. Nineteen school systems volunteered for the program however all have not been able to carry out all phases of the commitment. Mr. Bale's report stated there are approximately 50 school systems which have some type of physical fitness program and it is hoped the program will be expanded for the 1965-66 school year.

We discussed the athletic Injury Prevention Conferences and felt it could be handled more effectively if local communities conducted their own. It was suggested the committee serve as a clearing house when medical problems attached to sports arise. When these problems are referred to the committee, it would find a physician in that particular area to help. The committee decided it would not actively participate in future conferences, but would continue its interest in them.

The committee accepted as information only two resolutions from the Kentucky Education Association and the Kentucky Association of School Administrators. As it was felt that the resolutions might be of interest to the Council on Legislative Activities, it was taken by common consent that it be suggested to the Council on Communication and Public Service that these be passed on to the Council on Legislative Activities.

It was recommended to the Board of Trustees through the Council on Communication and Public Service that KMA Headquarters acquire the AMA exhibit "Medical Aspects of Sports" for the 1966 meeting of the Kentucky Education Association meeting.

Prior to the committee meeting, two recommendations were approved by the Council on Communications and Public Service and the Executive Committee of the KMA Board of Trustees so members could outline work to be undertaken during the summer. These recommendations were:

1. The chairman recommends that the KMA Board of Trustees request the County Medical Societies that do not have a school health committee chairman to appoint a chairman who would be the county society's liaison representative to the local board of education on matters of physical education and sports in that particular county. The KMA School Health Committee would then expect to maintain contact with the county chairmen and invite them to one or more state or district meetings a year to discuss school health matters.

2. The chairman further recommends that a room be made available during the KMA Annual Meeting at a time not to conflict with general sessions for a meeting of the county school health committee chairmen. A letter will be written to each chairman extending an invitation to such a meeting.

The Committee wishes to report it is implementing these recommendations.

School Health Committee. The growing importance of this Committee, particularly with the development and interest throughout the country in physical fitness is quite apparent. The very laudible work of the School Health Committee is recognized.

Mr. Speaker, I move the adoption and implementation of this section of the report. (The motion was seconded and it carried.)

Senior Day Committee

Carl Cooper, Jr., M.D., Bedford, Chairman

The chairman and members of the committee wish to express appreciation to those physicians who presented the highly successful 1965 KMA Senior Day program to the University of Louisville and the University of Kentucky graduating medical students.

The program was presented to the University of Louisville medical seniors on March 15 with the opening session taking place in the Rankin Amphitheater, Louisville General Hospital, and the afternoon session at the Medical Arts Building Auditorium. The students received the program with enthusiasm and expressed criticism and suggestions on questionnaires which were passed out before the start of the program. The constructive comments will be used in forming next year's program.

Guest speaker for the evening session was Harvey Hahn, D.D., Pastor, Otterbein Evangelical United Brethren Church in Dayton, Ohio. Doctor Hahn, who appeared through the courtesy of the General Motors Corporation, spoke on the subject of "Burnt Matches." He was very well received by all present.

The same program was presented to the seniors at the University of Kentucky Medical School, Lexington, on April 13, with much the same response as was gotten from the Louisville group. The students also offered some helpful suggestions for the committee members to consider when planning next year's program.

William K. Keller, M.D., professor and chairman of the department of psychiatry, University of Louisville School of Medicine, was the featured speaker at the U. of K. evening program. Delmas Clardy, M.D., president of KMA delivered an excellent talk at the opening session of both programs and received many favorable comments from the students on his topic, which was "The Great Society of Mediocrity." Copies of Doctor Clardy's talk are available at the KMA Headquarters Office and it is recommended reading for all members of the Association.

At the committee's meeting on December 3, 1964, members requested the Board of Trustees to appropriate $500 each year for the committee's use in paying for guest speaker's honorarium. This amount was requested to be set aside each year so that there will be no doubt at the last minute as to whether or not the money will be available. (This paragraph referred to Reference Committee No. 1.)

The chairman wishes to express his appreciation to members of the committee for their interest and cooperation in planning these very worthwhile senior day programs.

This Committee's report with the exception of Paragraph 2, page 15, was considered. It is obvious that progress continues in this area.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Advisory Committee to Woman's Auxiliary

Jesse T. Funk, M.D., Bowling Green, Chairman

Your chairman was contacted on several occasions for consultation by officers of the Auxiliary. Since no matters were officially brought to the attention of the committee, no meeting was held this year.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Disaster Medical Care Committee

William T. Rumage, Jr., M.D., Louisville, Chairman

The Committee has met during the past year and has continued the practice of inviting representatives of the State Health Department, the American Red Cross, the Kentucky Hospital Association, the University of Louisville and the University of Kentucky. For medical care at the time of disaster to be effective, it will be necessary to coordinate our activities with these groups and subsequently the committee has felt it worthwhile to continue to invite these representatives to the planning meetings.

During the past year nine packaged emergency hospitals have been located across Kentucky by the State Health Department and the United States Public Health Service. This brings the total number of hospitals to forty-five.

1. Your committee has been interested in the medical staff and organization of these hospitals so that they can be utilized to their fullest at the time of disaster.
2. Your committee has encouraged the disaster committee and the Kentucky Hospital Association to have its members develop their disaster plans and to test those plans.
3. Your committee has sent information to several communities in the commonwealth to encourage them to develop community disaster plans and to exercise those plans. It is apparent that the permanent hospitals, the packaged emergency hospitals and the communities should have coordinated disaster exercises.
4. Your committee continues to support the medical self-help training program and encourages the members of the Kentucky Medical Association to sponsor programs of medical self-help. To date nineteen thousand. seven hundred and six people have been trained this year.
5. The committee has continued to encourage the development of Red Cross First Aid Training Programs. We have endorsed the plans of the State Health Department and the American Red Cross to sponsor first aid programs for industry.
6. Your committee continues to receive reports from the MEND Program at the University of Louisville and the University of Kentucky.
7. The committee has further investigated the need for Good Samaritan Legislation and it is our recommendation that a planning committee be appointed to prepare appropriate and acceptable Good Samaritan Legislation. (This paragraph referred to Reference Committee Number 3.)
8. The committee has made recommendations for use of the shelter area in the KMA Headquarters Building. Immediate plans should be made with the State Health Department to include the Kentucky Medical Association Headquarters building in its disaster radio network.
9. The committee sponsored an exhibit of a packaged emergency hospital at the 1964 KMA Annual Meeting which was very well attended.
10. Thanks to the action of the delegates and trustees, a member of the committee was sent to the National Disaster Medical Care meeting in Chicago and another member of the committee will be sent to the regional meeting to be held in Washington, D. C.
11. Your committee is still investigating the feasibility of appropriate highway signs for emergency health facilities.
12. Your committee, in conjunction with the Kentucky Hospital Association, is sponsoring a questionnaire to determine the problems involved in the transportation of the sick and injured in Kentucky.

13. Your committee is working in conjunction with the State Health Department to develop the state disaster plan.
14. Your committee has again endorsed the request of the Flying Physicians for emergency medical supplies. It is hoped that the State Health Department will make the supplies available in the immediate future.

COUNCIL ACTION: It is recommended that the report of the Disaster Medical Care Committee be accepted as presented.

COUNCIL ON COMMUNICATIONS AND PUBLIC SERVICE
N. Lewis Bosworth, M.D., Lexington, Chairman
Carl Cooper, Jr., M.D., Bedford
Donald L. Graves, M.D., Frenchburg
Irving F. Kanner, M.D, Lexington
Ralph D. Lynn, M.D., Elkton
O. B. Murphy, Jr., M.D., Lexington
John Robbins, M.D., Louisville

Recommendations, Reference Committee No. 4

This report was studied with the exception of Section 7, Page 17. The Reference Committee is impressed by the continuing activities and expansion of this program.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Council on Allied Professions and Related Groups

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material in this report of the Council on Allied Professions and Related Groups is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.

2. Reports of the committees of this Council with the Council recommendations following each committee report. . .

3. Recommendations by the KMA Board of Trustees on the over-all contents at the conclusion of the report.

* * * * * *

The Council on Allied Professions and Related Groups met twice during this associational year, on January 7 and July 1, 1965.

At the first meeting, the members of the Council reviewed the duties of the Council as outlined in the KMA by-laws and discussed plans for the various committees serving under the Council. Specific recommendations were referred to the committees for consideration at their meetings and dates were set for most of the committee meetings. Committee activities for the previous year were reviewed and goals were set for this year.

At its second meeting, the Council welcomed two new committees that have been assigned to it this year. They are the sub-committee on Disability and Physical Impairment and the Cancer Committee. The Council also reviewed the proceedings of the KMA-KNA Joint Advisory Committee which met May 20.

Other committees serving under the Council are: Blood Banks Committee, Cancer Coordinating Committee, Dental-Nurse-Pharmacy Committee, Industrial Medicine Committee, Maternal Mortality Study Committee, Perinatal Mortality and Morbidity Study Committee, Physical Medicine and Rehabilitation Committee and Tuberculosis Committee.

The following are the final reports of these committees:

Recommendations, Reference Committee No. 4

It was noted by the Reference Committee the many and varied activities of the Council in addition to the two Sub-Committees, that is, the Disability and Physical Impairment and the Cancer Committee.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Blood Banks Committee

Ellis A. Fuller, M. D., Louisville, Chairman

The Blood Banks Committee met once during this Associational year on Thursday, May 13, 1965. Noting the committee's inactiveness in previous years, the members discussed the committee's purpose in great detail and agreed there are problems in the blood banking field which warrant the full attention of this committee.

The committee wants to send out a questionnaire to obtain more details on blood banking facilities in Kentucky, but intend to wait until the AMA completes a similar survey it is now conducting nation wide. Other future projects of the committee include interesting local medical societies to help improve problems of blood transfusions; studying the problems which pertain to proper supervision of blood banking facilities; and compiling and reviewing legislation other states have passed as it relates to blood and blood banking activities.

In reviewing the committee's 1964 final report and the council action thereon, (see following) the committee recommended to the KMA Board of Trustees through the Council on Allied Professions and Related Groups that the policy statement be accepted with the following changes:

Paragraph 1—

". . .The medical profession has primary responsibility for the care and treatment of patients and, therefore, has a paramount interest in evaluating facilities and procedures for blood procurement, storage, and use. . ."

should be changed to read:

". . .The medical profession has primary responsibility for the care and treatment of patients and, therefore, has a paramount obligation to evaluate facilities and procedures for blood procurement, storage and use. . ."

Also Paragraph 2—underlined section—

". . .—Should be a doctor of medicine." *should be changed to read:*

". . .—Must be a licensed physician."

Following a discussion of the recommendation made by the council on Allied Professions and Related Groups at its January 7, 1965 meeting which read:

". . .Members of the Council felt that an item that might appear on this committee's agenda would be to investigate the reasons why a central blood bank would not be more efficient than individual banks."

The committee requests that it be given more clarifying material and information in order that the problem might be thoroughly researched.

After discussing the blood banking activities on a local level, the committee recommended to the Board of Trustees through the Council on Allied Professions and Related Groups that a letter be written over the chairman's signature to the secretaries of the local medical societies urging them to establish a

Blood Banks Committee if one is not already part of their society and that the names of the members of this committee be forwarded to the KMA Headquarters Office. It was further recommended that a consultant be appointed to work with the chairman of the local Blood Banks Committee to research any problems that may arise.

Following a lengthy discussion by the members of the committee on the need for a dissemination of information to KMA members regarding blood and blood banking activities, it was taken by common consent that the committee recommend to the editor of the KMA Journal through the Council on Allied Professions and Related Groups that the committee be permitted to publish a symposium issue on blood banks, within the next year. Also that the committee would recommend a symposium editor to coordinate and prepare the material in accordance with the established policy of The Journal.

It was further recommended that Doctor Fuller canvass the state in finding physicians knowledgeable in this area to write the articles and that he send a list of the suggested authors to members of the committee so selections can be made.

The articles to be written will be selected from the following suggested titles: (1) Who needs a Blood Transfusion? (2) Does Your Patient need a Transfusion? (3) From Where Do You Get the Blood? (4) How Good is Your Blood, Doctor? (5) Sources of Blood. (6) How Do You Get Good Blood for Your Patients? (7) What Do You Do to Make Sure that Blood is Good? (8) Proper Administration of Blood. (9) Both Medical and Legal Hazards of Blood Transfusions. (10) Proper Management of a Blood Bank. (11) Proper Medical Use of Blood Components. (12) Medical Legal Survey of the Post Transfusion State. (13) Transfusion Reactions. (14) How to Avoid Legal Recourse.

BLOOD BANKS COMMITTEE ATTACHMENT

The committee members discussed the 1964 final report of the Blood Banks Committee and the council action taken on that report. "In recent years there has been a dramatic growth of blood banking facilities in the United States. The procurement of human blood and its transfusion to patients are medical procedures which require the direction and supervision of a physician. The ultimate objective of these procedures is the welfare of persons who require blood or blood derivatives. *'The medical profession has primary responsibility for the care and treatment of patients and, therefore, has a paramount interest in evaluating facilities and procedures for blood procurement, storage and use. This responsibility can best be discharged by medical societies at the local level.'*

"The American Medical Association's committee on Blood believes that component and constituent medical societies should be informed of proposed and existing blood banking services within the community and should offer guidance to them. In the opinion of the Committee, it is highly essential that the organization of new blood banking programs and the modification of existing ones should have, in the interest of public health and safety, *'the approval of the county or district medical society and therefore should be coordinated with existing approved blood banking facilities, that since a blood bank can well be considered a medical facility, the over-all director—the top authority in the blood bank—should be a doctor of medicine.'"*

Recommendations, Reference Committee No. 4

The considerable work undertaken by this Committee during the past year to re-organize in a most useful fashion, the blood banks, is recognized.

Mr. Speaker, I move the adoption and implementation of this section of the report. (The motion was seconded and carried.)

Cancer Coordinating Committee

Condict Moore, M. D., Louisville, Chairman

The Committee was appointed an official committee of the Kentucky Medical Association by action of its governing body at a meeting. I believe, in January. The committee replaces the formerly inactive Kentucky State Cancer Council. The Committee is composed of representatives of four organizations interested in cancer; namely, the Kentucky State Department of Health; The American Cancer Society; Kentucky Division, The American College of Surgeons; and the Kentucky Academy of General Practice. The Committee also has as members two men representing The Kentucky Medical Association. The membership of the Committee during the past year was as follows: C. Melvin Bernhard, M. D., Delmas M. Clardy, M. D., Robert H. English, M. D., Walter I. Hume, Jr., M. D., Arthur T. Hurst, M. D., Benjamin F. Rush, M. D., Ben Roach, M. D., Agnes A. Laine, M. D., Condict Moore, M. D., Chairman.

Since the Committee did not have official status until after the first of the year, only two meetings have been held between February and June. At the first meeting we discussed the program of the State Department of Health in cancer control. The Committee met in Doctor Teague's office in Frankfort. The following specific recommendations were made after considerable discussion, and were agreed upon in principle by the representatives of the State Department of Health: that funds currently being used for a Central Cancer Registry be diverted to the development and improvement of local cancer registries in individual representative interested hospitals throughout the State. It was felt that a Central Cancer Registry has value only if the local cancer registries in the community hospitals are well organized and feeding meaningful material into it and are also properly representative of the population of the State. This move was not intended to block the development of central registry date of processing in the future. It was meant as an essential first-step of reorganization at the source of all cancer data, the local hospital cancer registry, to form a firm basis for future work in cancer data gathering and analysis.

A second meeting was held on May 27, 1965 at the office of the American Cancer Society here in Louisville with representatives of that organization present. A discussion was held at this meeting of the program of the Cancer Society in state-wide control of cancer. After hearing an outline of the Cancer Society's program, most of the Committee felt that there was some overlap between the programs of State Department of Health and the American Cancer Society. Both organizations promised to meet before the next meeting of the State Cancer Coordinating Committee to try to iron out some such areas of duplication.

Four meetings are scheduled for the coming year, the first one to be a report by the Chairman on the current status of cancer registries and clinics in community hospitals throughout the State.

COUNCIL ACTION: It is recommended that the Report of the Cancer Coordinating Committee be accepted with the exception of the wording of page 2, line 4 which reads—"date of processing." The Council feels this should read "data processing."

Recommendations, Reference Committee No. 4

The new Cancer Coordinating Committee has quite obviously been quite active in attempting to salvage and preserve information which has become relatively unavailable through the Cancer Registry and it is noted that the decentralization of information is not a move to block a central Cancer Registry in the future.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Dental-Nurse-Pharmacy Committee

Melvin J. Weber, M. D., Ludlow, Chairman

At the request of Mr. R. W. Leake, 1963-64 president of the Kentucky Pharmaceutical Association, the KMA Dental-Nurse-Pharmacy Committee met on April 29 with representatives of the KPA. This meeting was in line with the recommendation of the 1963-64 KMA President who urged greater cooperation with allied groups in the interest of better relations and better services to the public.

The agenda for the meeting was developed from suggestions made from members of both groups. Both the pharmacists and the physicians and attendants felt that this was a very profitable meeting and the hope was expressed that this practice be followed in the future.

As a result of this meeting, the KMA Committee on Dental-Nurse-Pharmacy makes the following recommendations to the House of Delegates through the Council on Allied Professions and Related Groups (it is understood the pharmacists are making the same recommendations to their governing body):

1. That the medical profession be urged to go on record stating that it condemns the practice of one pharmacy prescription filling by business, industry, or unions. The committee further recommends that pharmacists refrain from releasing the names of drugs to insurance companies and patients, even though authorized by the patient and physician. The physician should use his own discretion as to whether he feels the prescription should be released.

2. That KMA take a similar position as the AMA on the problem of straight-line telephones to physicians' offices, which is the Judicial Council's expressed opinion "that the principle of free choice of physician applies as well as to the choice of a pharmacy.—Accordingly, the council looks with disfavor upon the use of direct telephone lines between a physician and a pharmacist on the theory that a patient is entitled to a written prescription which he can take to the pharmacist of his choice."

3. That the KMA take the position that the labelling of drugs on prescriptions should be stopped in that it has an adverse effect on a patient's relationship with the physician.

4. That KMA go on record as endorsing the statement pertaining to sample drugs made by the AMA in its 1964 Judicial Council Opinions and Reports:

> "It is the opinion of the Council that the physician himself is responsible for the control and custody of drugs once they come into his possession and in the high tradition of the medical profession, he should not dispose of these drugs in any way that could cause harm to others. The council is also of the opinion that the sale of these samples is unethical and that the disposal of them to individuals, currrently referred to as 'drug scavengers,' for repackaging and sale is also unethical.
>
> "The members of the Council believe that each physician should cooperate with the Federal Food and Drug Administration and with others who seek to prevent misbranding and contamination of drugs. The council is of the opinion that where it is not illegal, county medical societies should be encouraged to work out a system of collecting unwanted or unused drug samples so that these samples, under proper professional supervision, could be used for charitable purposes."

5. That KMA endorse the policy that pharmacists warn patients about repeated use of non-prescription items without medical attention and that it is a violation of the pharmaceutical code of ethics to prescribe over the counter.

6. That the KMA endorse the policy that prescriptions not be refillable after six months unless requested by the physician.

Recommendations, Reference Committee No. 4

It was felt by the Reference Committee that confusion existed in Section 1, Page 8. It was felt that this Section would be more clear if the present reading were changed from:

> "1. That the medical profession be urged to go on record stating that it condemns the practice of one pharmacy prescription filling by business, industry, or unions. The committee further recommends that pharmacists refrain from releasing the names of drugs to insurance companies and patients, even though authorized by the patient and physician. The physician should use his own discretion as to whether he feels the prescription should be released."

to read:

> "1. That the medical profession be urged to go on record stating that it condemns the practice of one pharmacy prescription filling by business, industry, or unions. The committee further recommends that pharmacists refrain from releasing the names of drugs to insurance companies and patients. The physician should use his own discretion as to whether he feels the prescription should be released."

It was further observed that the Board took exception to Section 3, Page 8, and recommended that the wording in this paragraph be changed to read as follows: "That the KMA take the position that the labelling of drugs be at the discretion of the prescribing physicians." It is the feeling of this Reference Committee that this wording should be altered as proposed by the Board.

Mr. Speaker, I move the adoption of this section of the report as corrected. (Motion was seconded and carried.)

Industrial Medical Committee

Gradie R. Rowntree, M. D., Louisville, Chairman

The Industrial Medicine Committee has met twice this year.

At the last meeting, the committee members reviewed the duties of this committee and the recommendations made last year to the KMA House of Delegates.

(1) We would like to encourage County Medical Societies to form Industrial Medicine Committees.

(2) We would like to inform those interested in industrial medicine and encourage their attendance at the AMA Congress on Occupational Health which will be held at the Murat Temple in Indianapolis, Indiana, October 12-14 concurrently with the Annual Convention of the Indiana State Medical Association.

The Industrial Medicine Committee met with eleven representatives of insurance companies and felt it was most beneficial. A summary of the major items discussed at that meeting is as follows:

I. What are some of the problems in industry as they relate to the insurance carrier and the doctor? What can physicians do to solve some of these problems?

It was brought out that insurance companies sometimes have a problem of getting reports from doctors on time. They also have trouble getting forms from employers.

A committee is working nationwide on a standard medical form. This may help in reporting. It must be remembered that insurance companies usually cannot pay compensation until they get the medical report.

II. Medical departments or first aid services in industry can be of great assistance in reducing disability. What can we do to improve this service?

(a) One representative said his company feels the service of a medical department is very neces-

sary to reduce disability. The company believes that management should be sold on first aid and inplant services. They recommend the use of services of nurses, physicians, and technicians when the company is large enough. He said it is sometimes difficult to find part-time physicians to staff a service in the plant. It was noted that physicians might be available at hours other than 8:00 a.m. (b) It was felt that the use of tetanus toxoid among employees should be promoted.

III. Should there be new legislation on workmen's compensation during the 1966 session of the legislature?

It was felt that no substantial changes need to be made in the workmen's compensation law, but there should be some refining of the law. It was brought out that the administration of the law in Kentucky is becoming more liberal. It was reported that the medical ceiling on a single case is no longer limited to $2,500. Physicians and insurance companies should get together with closer team work. Patients should be given everything they are entitled to.

If the physician or company knew the patient had legal implications, it would be helpful to report it to the insurance carrier. It would also be helpful if the insurance carrier would report same to the physician or company where the worker is employed.

Insurance companies are interested in getting a list of doctors who would take care of industrial cases. The KMA Industrial Medicine Committee suggested that insurance carriers get in touch with the County Medical Society about this.

IV. Discussion of the "Objectivities of Medical Rehabilitation." Rehabilitation is to restore function of the individual to usefulness. Insurance carriers need to get men back to work as soon as feasible.

Now days, injured men receive so much compensation when they are not working, it is hard to get them back on the job. Vocational rehabilitation helps. It is good business to get the men back to work. Insurance companies provide for medical services, but few provide vocational rehabilitation.

NOTE: The committee was pleased to have Kenton D. Leatherman, M. D., a member of the KMA Committee on Physical Medicine and Rehabilitation, join them at this meeting to discuss rehabilitation objectives.

Recommendations, Reference Committee No. 4

Industrial Medicine Committee. The report of the Industrial Medicine Committee was studied. It was the opinion of the Reference Committee that Paragraph 1, Page 11, which reads:

"If the physician or company knew the patient had legal implications, it would be helpful to report it to the insurance carrier. It would also be helpful if the insurance carrier would report same to the physician or company where the worker is employed."

should be deleted. It was the unanimous opinion of the Committee that this jeopardized patient-physician relationships by violation of confidence.

Mr. Speaker, I move the adoption of this section of the report as amended. (Motion seconded; carried.)

Maternal Mortality Study Committee

John H. Siehl, M. D., South Fort Mitchell, Chairman

The Maternal Mortality Study Committee has had two meetings this year. They were held in Louisville and in Covington.

Your committee discussed approximately 24 cases, some of which will appear in future publications of the KMA Journal. There were a number of suggestions of a general nature on how the committee might increase the effectiveness of its work. It was felt that the cooperation of the profession with the committee was maintained.

The committee members feel that education of patients is most important in this area.

Your chairman wishes to thank those members for their efforts in making this such a successful year and for serving on this KMA Committee.

Perinatal Mortality and Morbidity Study Committee

Guy C. Cunningham, M. D., Ashland, Chairman

A meeting was held at the Terrace Room of the Imperial House in Lexington, Kentucky, of the Perinatal Mortality and Morbidity Study Committee of the Council on Allied Professions and Related Groups at 12 noon, June 24, 1965. Those present were the chairman, Guy C. Cunningham, M. D., Ashland, Ky., Jeffries L. Blackerby, M. D., Lexington, Ky., Robert McLeod, M. D., Somerset, Ky., and William C. Young, M. D., Hopkinsville, Ky. Also present at this meeting, by special invitation, was Judith A. Hood, M. D., representing the Maternal and Child Health Division of the State Health Department. Those absent were Keith M. Coverdale, M. D., Bowling Green, Ky., John H. Doyle, M. D., Louisville, Ky., William R. Gabbard, M. D., Owensboro, Ky., Lawrence U. Gilliam, M. D., Corbin, Ky., Robert Rice, M. D., Richmond, Ky., William J. Temple, M. D, Covington, Ky., and Fred Weller, M. D., Middlesboro, Ky.

After a preliminary discussion involving the minutes of the last meeting and bringing the new members of the Committee up to date the following items were discussed on a formal agenda.

I. A thorough review of the Kentucky Maternal and Infant Statistics through 1963 was undertaken, with special emphasis given to those counties where the mortality and morbidity statistics were greater than that of the nation as a whole. Special emphasis and study was given to Christian County, where these statistics were especially bad. It was noted by a member of the committee, William C. Young, M. D., that a considerable number of these infant deaths occurred in an army hospital in this county.

II. The subject of Amino Aciduria was discussed in all of its ramifications including the Phenylketonuria problem. The consensus of opinion of the committee was that we of the Kentucky State Medical Association should back legislation in favor of not only an accurate test for the early detection of Phenylketonuria, but also tests for the early detection of any Amino Aciduria in infancy and childhood.

III. Premature and Newborn Training Centers in the State of Kentucky, particularly ones that might be associated with either of the two Medical Schools for training Kentucky Nurses, particularly nursing supervisors and physicians should have the full support of this committee. The State Health Department was particularly anxious to see such centers established, not only at the two medical schools and medical centers in the State of Kentucky, but also perhaps in some of the other areas of the state where facilities and personnel were available for such training programs.

IV. Silver Nitrate Prophylaxis in the Eyes of Premature Newborn Infants, was brought up for discussion and the consensus of opinion of the entire committee was that we should recommend to the council on Allied Professions and Related Groups that it recommend to the Kentucky State Medical Association again that an attempt be made to change the old State Statute, requiring silver nitrate administration to premature newborn infants in the state of Kentucky. The committee felt that in view of the newer antibiotic eye ointment available, i.e., Achromycin Ointment and Erythromycin Ointment as well as others, that many of the chemical conjunctivitis reactions from silver nitrate were no longer necessary. The committee felt strongly that some prophylaxis in the eye should be continued, par-

ticularly in view of the rising incidence of veneral disease in the state. However, it seems to us that many of the untoward reactions which occur in such a high percentage of cases with the silver nitrate prophylaxis could be eliminated if the discretion of what prophylaxis to be used were to be left to the discretion of the individual physician in attendance. We strongly urge that this matter be given due consideration and steps taken to amend the statute through proper legislative procedures. (Referred to Reference Committee No. 3).

V. Cooperation of this committee with the Kentucky State Health Departments Division of Maternal and Child Health and the Committee of the Fetus of Newborn of the American Academy of Pediatrics. In view of the fact that each of the three mentioned agencies above are primarily concerned with the mortality and morbidity of normal human beings and the elimination of deaths and damage during the process of reproduction, it was felt that complete cooperation was necessary. It is our intention during the forthcoming years to see to it that there are proper coordinating efforts in the programs so that the common cause can best be served. In view of the fact that your chairman is also the chairman of the Committee of the Fetus and Newborn of the American Academy of Pediatrics, such a cooperative effort should be easily obtained.

VI. Modification of the reorganization of the Committee on Perinatal Mortality and Morbidity. The committee would like to recommend to the Council on Allied Professions and Related Groups, that some reorganization of the Perinatal Mortality and Morbidity Study Committee might be in order in that we would like to see appointed on next year's committee in addition to men primarily interested in the field of Pediatrics, an obstetrician, an anesthesiologist, and a pathologist. We feel that the addition of these three allied specialties would enable the committee to function more efficiently in the detail studies of the problems that might be presented to such a committee. It was noted that in many cases the opinion of an obstetrician would be helpful, particularly in the study of individual cases and diseases. An anesthesiologist would be helpful to the committee in its efforts to improve resussitation procedures of the premature newborn and a pathologist would be able to add valuable interpretation in the discussion of case material which might be presented to this committee. (This paragraph referred to Reference Committee No. 1).

The committee through its chairman would like to thank the Council for being able to participate with it in the past year's work and would hope that we might be of more value through more frequent meetings in the forthcoming year.

COUNCIL ACTION: It is recommended that the report of the Perinatal Mortality and Morbidity Study Committee be accepted as presented. The Council would like to call attention to paragraphs 4 and 6. It is noted that paragraph 6 would be the responsibility of the Board of Trustees, and the Council recommends paragraph 4 be referred to the Council on Legislative Activities.

Recommendations, Reference Committee No. 4

This report was studied, with the exception of Section 4, Page 13, and Section 6, Page 14. Considerable attention was given to Section 2, Page 13, concerning the subject of Amino Aciduria. The Reference Committee does not feel that testing for such defects should be on a legislative compulsory basis and that it should be on a voluntary basis. This attitude was re-inforced by a representative of the State Department of Health. The opinion conveyed by this representative of the State Board of Health was that the State Board of Health would prefer to have this on a voluntary basis at the present time. Attention is also directed to Resolution J, introduced by Hollis Johnson, M.D., Jefferson County. This Reference Committee feels that Section 2, Page 13, should be deleted.

Mr. Speaker, I move the adoption of this section of the report as amended. (Motion seconded; carried.)

Tuberculosis Committee

Joseph Humpert, M. D., South Ft. Mitchell, Chairman

The TB Committee met once during the Associational year on Thursday, June 10, and had as their guests: Doctor Stuart Lauder, C. M. Director, TB Control, Department of Health, Frankfort; Thomas M. Layton, Executive Director, State TB Hospital Commission, Frankfort; and Thomas P. Summers, Executive Director, Kentucky TB & RD Association, Louisville.

The chairman revealed the following statistics for the committee's information. In 1963 there were 54,042 newly reported active cases of TB in the U.S. and about 10,000 additional patients had a recurrence of the disease and 9,311 deaths were caused. It was pointed out that Kentucky doesn't have too good of a record ranking seventh highest in cases reported and second highest in death rate due to Tuberculosis. In 1963, there were 1,190 new cases of TB in Kentucky and 269 deaths were reported in Kentucky; Arizona is the only other state higher than Kentucky on deaths due to TB.

Mr. Summers reported that the TB testing program in Kentucky is moving along quite well and there have been a number of counties participating in this program where all the school children are being tested. He pointed out that Metcalfe County is the only one thus far to have complete adult-child coverage in the TB program. He said that an estimated 75,000 of the approximate 780,000 school children have been tested during this year. Mr. Summers also stated that J. Ray Bryant, M. D., chairman of the Co-ordinating Committee of the TB & RD Association, which is set up to promote TB testing on school children, will write a letter to all county society doctors informing them of the TB testing program and urging them to participate.

Doctor Lauder reported the Health Department is continuing to test school children in those areas where sufficient personnel exists. He felt the Health Department has the machinery and framework for a first rate TB control program in Kentucky; that mobile units are an excellent method in controlling TB; and that more public health nurses are needed. Doctor Lauder said he is using a federal project grant to hire more nurses who will be used to clean up the backlog of work in certain counties.

In discussing various problems witnessed by the State TB Hospital Commission, Mr. Layton said paramount among these is that physicians in TB hospitals are not paid enough. He asked the committee's endorsement that the salary structure for these physicians be determined by the State TB Hospital Commission. The committee recommends to the House of Delegates through the Council on Allied Professions and Related Groups that KMA go on record endorsing the proposal that salaries of physicians employed in TB Hospitals be determined by the State TB Hospital Commission rather than the State Department of Personnel.

It was pointed out that another Campbell House Conference will be held in Lexington in November of this year and the theme will be "Theory and Practice in TB Control."

The members read and discussed two letters Doctor Lauder wrote to Oscar Thompson, M. D., Pikeville, relative to a TB survey being run by the U.S. Public Health Service through three Appalachia Hospitals. Doctor Lauder said the program is a result of a letter written by the Governor to the President asking for help in this area. The TB survey is to be

conducted for one year and if it is successful, other hospitals in the region will participate.

COUNCIL ACTION: It is recommended that the report of the Tuberculosis Committee be accepted as presented. The Council requests that Mr. Thomas Layton, Executive Director, State TB Hospital Commission, Frankfort, provide answers to the following questions prior to the Board of Trustees action on this report and that these questions be added as an addendum to this council report.

1. Who appoints the members of the State Tuberculosis Hospital Commission?
2. Who is on the Commission now?
3. Why should the commission set the salaries of the physicians in the hospitals?
4. Under the proposal, would the salaries established by the Commission be subject to review by the State Department of Personnel?
5. Would the change require legislative action?

Addendum to the Report of the Tuberculosis Committee

The following questions were answered by Mr. Thomas Layton, Executive Director, State TB Hospital Commission, Frankfort:

1. Who appoints the members of the State Tuberculosis Hospital Commission?
The Governor appoints four of the five members of the Commission. The Commissioner of Health is an ex officio member.
2. Who is on the Commission now?
C. C. Howard, M. D., Chairman, Glasgow; Mr. Howard B. Hunt, Louisville; Boyce E. Jones, M. D.; London; Alec Spencer, M. D., West Liberty; Russell E. Teague, M. D., (ex officio) Frankfort; The Commission is usually composed of four physicians and one layman.
3. Why should the Commission set the salaries of the physicians in the hospitals?
The Commission is responsible for the government and operation of the state tuberculosis hospitals. The employment of physicians for a program of this type is so vital to the successful operation of the entire program that the terms of employment including salary should be controlled by the Commission. Since the Commission is composed largely of physicians, it appears that the Commission (rather than the State Department of Personnel) is in a better position to determine the salaries necessary to employ qualified physicians for the hospitals. Salaries should be set high enough to enable the Commission to employ graduates of medical schools located in the United States. The salaries of physicians employed by the University are established by the University and are not not reviewed by the State Department of Personnel.
4. Under the proposal, would the salaries established by the Commission be subject to review by the State Department of Personnel?
No.
5. Would the change require legislative action?
Yes.

Recommendations, Reference Committee No. 4

The report of this Committee and addendum were carefully considered. It is the opinion of the Reference Committee that the proposals are valid.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Physical Medicine and Rehabilitation

William K. Massie, M.D., Lexington, Chairman

The activities of this committee in 1964-65 are varied. The objectives outlined in this committee report for 1963-64 formed the basis for the initial effort. However, new problems and more objectives have materialized since the members concentrated on various facets of these objectives. The current reports on the activities pertaining to each objective previously stated are as follows:

1) *Provision of a simple directory of available rehabilitation facilities within the state*: such a directory is in the process of formulation and will be published in the KMA Journal. It is planned that this information will be provided also in pamphlet form, to provide the KMA member with up-to-date information on the available facilities for rehabilitation, various schools for re-training in the varied programs under which this re-training can be obtained. This report will provide a map of the state showing the various regional centers of training and the activities offered in each center by the various departments of the state government.

2) *Ascertain the attitude of insurance carriers operating within the Commonwealth toward rehabilitation*: A spring meeting with the principal carriers illustrated a sincere interest in this facet of workmen's compensation and liability. Since this represents an appreciable medical expenditure, they were gratified to know that the KMA was also sincerely interested in the problems inherent in this program. For example, they recognized rehabilitation terminating in return to the original occupation was actuarially successful, but where the initial injury was too severe to effect re-employment in the same position, under the present interpretation of workmen's compensation law, the expenditure was not feasible. (A worker who is unable to return to his original occupation is interpreted by the Court of Appeals of the Commonwealth to be totally and permanently disabled.) The Committee wanted a definite commitment in answer to the question "would the insurance carrier accept expenses for rehabilitation if the patient was unable to return to his original occupation and if he received re-training in another capacity simultaneously?" The current interpretation of the Court of Appeals of permanent disability provides a barrier for cooperation by the insurance carriers. They, however, signified a real interest in a return meeting and discussion of this problem in the light of the proposed objectives of this committee.

3) *Formulation of a cooperative effort between the State Department of Rehabilitation, Re-training, Re-employment, relocation and Welfare designed to terminate in the re-employment of an injured worker*: A conference between this committee and the heads of the Departments of Economic Security, Labor, Education, and Vocational Rehabilitation brought into focus many problems, but all participants seemed genuinely glad to discuss them informally. For example, many states have institutions which provide rehabilitation and re-training simultaneously for those workers unlikely to return to the occupation with which they are familiar. Kentucky is not one of them. If such an institution is feasible economically, would the interpretation of the workmen's compensation law mitigate against general use of it? An award of total permanent disability provides a former worker with an excellent basis for a claim for social security on medical grounds. Hence, the father of a large family might conceivabiy receive more from social security, plus aid to dependent children, plus exemption from all taxes than if he were working at his former full-time job.

The problem of the temporarily impaired worker destined to return to his original occupation, but with a work tolerance lowered by the imposed inactivity of a prolonged recuperative period was discussed. There was general agreement that paragraph 320.100 of the workmen's compensation law provides incentive for gradual on-the-job rehabilitation while providing the patient with a partial impairment with a job assignment which would increase requirements commensurate with his improved work tolerance. This is a highly commendable section. It, however, is little used, because the employer of only a few workers rarely has jobs for a partially impaired work-

er. Also this frequently runs counter to union regulations or job seniority regulations of the employer.

The problem of re-employment of older workers was considered. Social security is so designed that it often forces a capable and able worker to accept inactivity in order to receive social security. This limits an individual's income to the social security level. The problem of the employment of the handicapped following optimum rehabilitation is felt to have no generally accepted approach in the Commonwealth. Why rehabilitate for future unemployment?

The status of work welfare was considered. This has many ramifications and is yet unsolved. These and other problems were discussed and Commissioner Cabe said that these would be continued in a conference to be sponsored by the Department of Labor to be held in the fall of 1965 on rehabilitation and workmen's compensation. Representatives from all interested groups, including Kentucky Medical Association, Kentucky Bar Association, and the Association of Insurance Carriers, would be invited to participate in the conference.

4) *Consideration of measures to stimulate motivation of the disabled and discourage measures now in force which effectively stultify this motivation*: It becomes apparent that all activities of the committee revolved around these measures and have been mentioned in the activities above.

5) *Appointment of a sub-committee of the Committee on Rehabilitation to investigate and propose a standard for impairment ratings*: This committee was appointed by the Board of Trustees, has met, and is in the process of selecting data from existing programs in other states preparatory to formulating and directing their own activities. Currently the chairman, Kenneth S. Phillips, M. D., feels that any report would of necessity be incomplete and premature.

6) *Action taken in opposition to Section 303 of HR 6675 (King-Anderson)*: This section proposed to allow workers temporarily disabled for six consecutive months to be eligible for social security. Such payments would run concurrently with those already received under individual state workmen's compensation laws. The effect on motivation for any provided rehabilitation is obvious. The chairman of this committee therefore testified before the Senate Finance Committee in opposition to this section, recommending that it be deleted in its entirety. Should this not be acceptable, certainly deletion of the dual compensation section seemed in order. This statement is appended to this report.

7) *Current interpretation of the Workmen's Compensation Law by the Court of Appeals* (mentioned above) awards to the worker permanent and total disability if he is unable to return to his original job assignment. This relation of total disability to job occupancy rather than functional physical impairment has various deleterious effects on the rehabilitation of a worker for re-employment in any capacity.

a) The family of a worker so rated may be eligible for Aid to Dependent Children and the total tax-free income may approach the wages which a worker with a physical impairment and with little education might expect to earn, thus making rehabilitation and re-training less enticing.

b) A worker with some physical impairment may find it hard to compete for a job of unrestricted heavy labor with an ample number of uninjured workers. Rather than seek re-training in any job which might require relocation, he is encouraged to try for total disability.

8) If HR 6675 as presented to the Senate becomes law, after one year he would be eligible for social security concurrent with workmen's compensation pay. Under such conditions it would be hard to find employment which would provide a larger income.

There are factors, however, unrelated to the worker himself which predispose to a long dependence upon workmen's compensation and/or welfare. Under the Workmen's Compensation Law the insurance carrier is responsible for returning the worker to the optimum working condition within the medical limits provided by the law. However, if it becomes apparent that the worker will certainly be unable to return to his original occupation, the carrier is little interested in providing funds for rehabilitating this individual to the optimum when such efforts would not terminate in a return to unrestricted activity, and total disability payments would be demanded subsequently. This also prevents the physician from instigating measures to rehabilitate and retrain a worker early following a serious injury. For example, should a man receive an amputated lower leg working in the coal fields, he would be unable to return to his original occupation. This would be apparent within a few days after injury. This man might be trained to use his hands for some more sheltered occupation from a very early date. The carrier would certainly not be encouraged to finance rehabilitation preparatory to such re-training until the case had been settled. Therefore, if the objective is re-employment of the highest percentage of physically impaired workers following injury, a premium must be placed on rehabilitation and re-training at a very early stage following injury. The Workmen's Compensation Law already provides for funds to rehabilitate the injured worker and weekly allowances based on his previous wage. The state already provides schools for re-training and provision for relocation and re-employment. To have these factors combined to produce a re-employed worker only requires that the final disability evaluation be closely related to the actual functional physical permanent impairment to the individual resulting from the injury, rather than job occupancy and other socio-economic and educational factors. Thus a worker would not be penalized by acquiring very early a new skill through re-training which would be provided concurrently with rehabilitation and terminate in re-employment.

A committee from the Kentucky Bar Association is presently working on legislation to be presented to the 1966 House of Legislature, designed to influence this problem. Since your Rehabilitation Committee has felt that this is the single most important issue to be clarified, we felt that the altered legislation proposed by this committee can be formulated in time to be presented to our House of Delegates for its consideration. Any proposed legislation which is presented to the 1966 House of Legislature endorsed by the Kentucky Medical Association and the Kentucky Bar Association would stand a far better chance of weathering the opposition to it.

MEASURES FOR SPECIFIC ACTION BY KENTUCKY MEDICAL ASSOCIATION:

1) Approve the printing by the Journal in booklet form for distribution to KMA members the directory of available rehabilitation, re-training, re-employment and relocation facilities in the state.

2) Approve, if acceptable, the statement of the legal committee of the Kentucky Bar Association relative to the disability status of workers unable to return to their original occupation, or, in lieu of this, formulate suggested legislation for consideration by the 1966 House of Legislature relative to the above subjects. (This paragraph referred to Reference Committee No. 3.)

3) John Ashworth, M. D., resigned from this Committee and requested replacement. Robert Izard, M. D., of the University of Louisville, who replaced Herman Wing, M. D., as Chief of Rehabilitation, might be a likely appointment.

COUNCIL ACTION: It is recommended that the

report of the Physical Medicine and Rehabilitation Committee be accepted as presented. The council recommends that this report and its addendum pertaining to the Kentucky Bar Association recommendation, which would change the Workmen's Compensation Law, be referred to the Legislative Council. At the request of the council, a statement made by the chairman before the Senate Finance Committee concerning HR-6675, Social Security Amendments of 1965, is to be made part of this report.

As chairman of the Council on Allied Professions and Related Groups, I would like to express my appreciation to the members of the Council and to the committee members who served under the Council.

COUNCIL ON ALLIED PROFESSIONS AND RELATED GROUPS
William K. Massie, M.D., Lexington, Chairman
Guy C. Cunningham, M.D., Ashland
Ellis A. Fuller, Jr., M.D., Louisville
Joseph Humpert, M.D., S. Ft. Mitchell
Gradie R. Rowntree, M.D., Louisville
Melvin J. Weber, M.D., Ludlow
Kenneth S. Phillips, M.D., Lexington
Condict Moore, M.D., Louisville

Recommendations, Reference Committee No. 4

This report was considered by the Reference Committee with the exception of Section 2, Page 23. The report was discussed by W. K. Massie, M.D., in some detail. The Reference Committee wishes to commend Doctor W. K. Massie for his extraordinary efforts in this area and, particularly, his energy and initiative in appearing before the Committee on Finance of the United States Senate.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the Council on Medical Services

Page 12 Paragraph 2, Pertaining to the New Orientation Program of the Kentucky Medical Association

There was some discussion regarding the new Orientation Program and the fact that it is good for both doctors from medical school and those coming in from out of state. It was suggested that if a new doctor does not take advantage of the program, more personal contact be made by letter and a follow-up by Mr. Armstrong when he is in the vicinity of the doctor.

Recommendations, Reference Committee No. 4

This portion assigned was considered separately and in context with that portion of Report 15 pertaining to the Orientation Committee.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded; carried.)

Resolution J
Hollis Johnson, M.D., Jefferson County

WHEREAS: There has been extensive publicity in the medical and lay press regarding the importance of PKU testing, and

WHEREAS: Early detection in phenylketonuria or PKU is very important and much interest in this matter has been aroused by the public, and

WHEREAS: Some lay groups have gone on record as advocating compulsory legislation which would require PKU testing of all newborns if adopted, and

WHEREAS: A Committee has been appointed by the State Health Commissioner to study PKU testing and after considering, among other things, the recommendations of the Committee on maternal and child care of the American Medical Association and the American Academy of Pediatrics, it is recommended by all groups and Committees that *voluntary* PKU screening programs be adopted everywhere, therefore

BE IT RESOLVED, that the Kentucky Medical Association, through its Board of Trustees and proper Committee, endorse and encourage state-wide testing of all newborn babies of PKU on a *voluntary* basis, and

BE IT FURTHER RESOLVED, that the Kentucky Medical Association encourage the Kentucky Hospital Association to cooperate in the testing program for the purpose of obtaining blood cycles on newborn infants, and

BE IT FURTHER RESOLVED, that KMA express themselves as opposed to any compulsory legislation regarding PKU testing.

This Resolution was studied separately and in conjunction with the report of the Perinatal Mortality and Morbidity Study Committee, Page 13, Section 2. In view of the discussion and evidence presented, it was felt that the Resolution should be adopted with the exception that the last paragraph, BE IT FURTHER RESOLVED, be struck and that in the remaining BE IT FURTHER RESOLVED, a correction be noted and that "blood sample" be substituted for "blood cycle" in the last paragraph. The Committee endorses this Resolution as amended.

Mr. Speaker, I move the adoption of this section of the report as amended. (Motion seconded; carried.)

Mr. Speaker, I should like to express my appreciation to the members of this Reference Committee for their diligence and dedication and their great help in developing the report of this Committee.

Mr. Speaker, I move the adoption of this report as a whole. (The motion was seconded and carried.)

REFERENCE COMMITTEE NO. 4
Andrew M. Moore, M.D., Lexington, Chairman
William E. Becknell, M.D., Manchester
Philip D. Hitchcock, M.D., Edmonton
Walter I. Hume, Jr., M.D., Louisville
Dwight L. Blackburn, M.D, Berea

Following the presentation of Reference Committee No. 4, Harold B. Barton, M.D., Corbin, chairman of the Board of Directors of the Kentucky Educational Medical Political Action Committee, made an oral report to the members of the House on the progress of his organization.

REFERENCE COMMITTEE NO. 5†

Louis M. Foltz, M.D., Chairman

Reports on Medical Service

‡ See Note (†) bottom of column 1, page 972

The following reports and resolutions were considered by this reference committee:

14. Report of the Council on Medical Services (with the exceptions of page 2, first full paragraph starting with "Members of the Council" and the last full paragraph at the bottom of the page starting with "The AMA has adopted a policy" will go to Reference Committee No. 2; page 4, numbered paragraph 2 referred to Reference Committee No. 3; page 5, numbered paragraph 4 at the top of the page referred to Reference Committee No. 3; and page 12, first full paragraph starting with "There was some discussion" referred to Reference Committee No. 4.)
23. Report of the Board of Directors, Kentucky Physicians Mutual, Inc.
24. Report of the Board of Trustees, Rural Kentucky Medical Scholarship Fund
27. Report of the Technical Advisory Committee on Indigent Medical Care

32. Report of the Advisory Committee to Selective Service
34. Report of the Representative Mental Health Planning Commission
Resolution A—Administrative Relationship Between Hospitals and Private Practitioners
Resolution B—VA Prescription Procedures
Resolution G—Guidelines for Planning Community Medical Services
Resolution K—Private Use of Medical Students as Physicians for Hospital Profit

Report of the Council on Medical Services

PREFACE

Procedures for reports of councils and standing committees of KMA to the House of Delegates are provided for under Chapter VIII, Section 4 of the Bylaws, which reads in part:

". . . .Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. . ."

The material in this report of the Council on Medical Services is presented in the following order:

1. Actions and recommendations by the Council which it undertook on its own initiative.

2. Reports of the committees of this Council with the Council recommendations following each committee report.

3. Recommendations by the KMA Board of Trustees on the overall contents at the conclusion of the report.

* * * * * *

The Council on Medical Services met this year on June 10 and reviewed the duties assigned to the Council and the report submitted to the House of Delegates last year. It was noted that all recommendations made by the Council last year were being implemented and the recommendation pertaining to the problem of coordinating the various health agencies now existing through the various state departments had been referred back to this Council. It was reported that with the approval of the House of Delegates last year, a KMA Judicial Council was formed, and the Medical Discipline Committee which formerly served under this Council no longer exists.

Members of the Council reviewed other committee and council actions to include the questionnaire on Medical Education and the recommendation of the Hospital Committee concerning the formation of a voluntary area-wide hospital planning commission for Kentucky. Your Council on Medical Services strongly endorses this recommendation of the Hospital Committee and urges its approval. (This paragraph referred to Reference Committee Number 2.)

The Council members also reviewed the actions of the AMA Council on Medical Services. A thorough discussion was held concerning the AMA Council's four volume report on the Costs of Medical Care. It was noted that the recommendations made in the report to the 1964 Session of the AMA House of Delegates are in the process of being implemented and special committees have been formed to conclude the necessary studies.

The Health Insurance Council "short form" common insurance form has been revised and a report concerning this will be included in the KMA Insurance Committee's final report.

The AMA had adopted a policy urging physicians to participate in Voluntary Area-Wide Planning for Hospitals and Health Related Facilities. We are pleased that some County Medical Societies in Kentucky have already formed Area-Wide Hospital Committees and as mentioned above a recommendation has been made urging that KMA take the lead in forming such a committee on a state wide basis. (This paragraph referred to Reference Committee Number 2.)

The following reports of the committees serving under the Council are herewith submitted:

Comments, Reference Committe No. 5

This is a split report so that paragraph 2 on page 2 is given to Reference Committee No. 2; page 4, item 2, referred to Reference Committee No. 3; page 5, item 4 and council action, paragraph 3 referred to Reference Committee No. 3.

Aging Committee

Earl P. Oliver, M. D., Scottsville, Chairman

Members of the Aging Committee met at the KMA Headquarters Office on April 20 to prepare its final report to the 1965 House of Delegates.

The members were briefed on the Kentucky Commission on Aging on which two KMA physicians are members, and the view was expressed that the medical profession should continue to be represented on this group. The chairman reported on the recently held AMA Conference on Aging and Long-term Care in Chicago, and said much discussion was held on discouraging the practice of retirement for the aged citizen due to age alone.

The committee discussed the accreditation of nursing homes and future medical care programs and made several recommendations to be included in the committee's final report to the House of Delegates.

The committee members also discussed in great detail the present Medical Assistance to the Aged program and future Medical Assistance to the Aged programs. It was felt that to improve our present MAA program, and to be better prepared to intelligently and efficiently participate in whatever federal program Congress enacts this year, we need a definite program with which to proceed. The Committee on Aging therefore submitted the following recommendations to the House of Delegates through the Council on Medical Services:

1. The KMA, through the appropriate committee composed of general practitioners and practitioners of the various specialties, prepare a realistic and acceptable fee schedule for the various services provided by physicians to persons over age 65. This schedule should include medical service rendered by physicians and also laboratory, X-ray, anesthetics, medical materials, and appliances furnished by physicians to these patients. The fee schedule should consider payment of mileage on home visits and extra fees for night and Sunday services.

The committee should hold in mind in preparing the fee schedule that these services will be furnished to some wealthy persons and to able-bodied persons, most of whom are able to care for their own medical expenses; as well as to the medically indigent aged who will comprise only about 15% of the total recipients of the program.

A suitable fee schedule to use as a guide might be our Military Dependent Medical Care Act fee schedule. Further, this fee schedule should be renegotiated at regular intervals, the intervals being no longer than every five years; and that fees be adjusted in accordance with the cost of living index. Further, that changes in the program be made only by negotiation, and none by "Executive Order."

2. The KMA insist that the Kentucky Legislature pass legislation which would make the Kentucky Department of Health the administering agency of any Medical Assistance to the Aged Program, rather than joint administration by the Department of Health and the Department of Economic Security, since this is a Health Program and not a Welfare Program.

The KMA also strongly advise and recommend that the Blue Cross and Blue Shield Plans, Inc., of Kentucky, or any acceptable qualified and approved insurance carrier licensed in the state, be appointed as Fiscal Intermediary for any Medical Assistance to the Aged Program. (This was referred to Reference Committee No. 3.)

3. The KMA recommend that any Physician or eligible recipient of services under any Medical Assistance Program to the Aged in Kentucky, be free to participate or not to participate in the program at his own discretion, and also free to select the cases in which he wishes to participate or not to participate, on an entirely voluntary basis.

4. The KMA members refuse to participate in any Medical Care Program for the Aged in any way after 1/1/66, unless the heretofore mentioned recommendations are implemented in an acceptable manner. (This was referred to Reference Committee No. 3.)

5. The KMA go on record as continuing its support of nursing homes and encourage the future construction of adequate nursing home facilities, but encourage the elimination of luxury items in order to make the cost of care more in proportion to the income of the aged patient.

COUNCIL ACTION: It is recommended that the report of the Committee on Aging be accepted with the following amendments. The Council recommends the following introductory phrase be added at the beginning of *Recommendation Number 1.* "In the event that any Federal or State Medical Assistance to the Aged Program imposes a fixed fee for services rendered by physicians," the KMA etc. The Council further recommends that *Recommendation Number 4* be omitted from the report.

Recommendations, Reference Committee No. 5

Aging Committee. This report was studied in detail, and discussion from interested members of the society was heard. In view of this fact that the medical fee scheduling was given in part to the Reference Committee No. 3 this Reference Committee was of the opinion that Reference Committee No. 3 would consider the whole item; namely, page 3, No. 1 and 2 and page 5, No. 4, action of the council.

In addition, this committee identified the recommendation made by this committee and agreed with this recommendation that any physician or eligible recipient of services under any medical assistance program to the aged be free to participate or not to participate.

We agree with the recommendation that the KMA go on record as continuing its support of Nursing Homes, encourage construction and adequate care with income of the patient considered in all plans.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded.)

During the discussion of the reference committee report, Earl P. Oliver, M. D., Allen County, made the following statement and recommendation:

"Of course we are all opposed to any type of third party medicine or socialized medicine, however, as part of the democratic process I believe we should advise the AMA of the views of the KMA in the utilization of Public Law 89-97."

"However, much of our present dissatisfaction probably is due to the present operation of the MAA and PAA programs in Kentucky—I therefore recommend that the KMA House of Delegates go on record as opposing the Kentucky MAA and PAA Program as it is presently administered in Kentucky." There was a second to the recommendation. The recommendation passed.

The motion on the adoption of the reference committee report as amended passed.

Advisory Committee to Blue Cross

George W. Pedigo, M. D., Louisville, Chairman

Your Advisory Committee to Blue Cross consists of 17 members from various sections of the state. A meeting is held monthly, usually four members at a time, at the Blue Cross-Blue Shield Building in Louisville, to review questionable or controversial claims that have been submitted to the Blue Cross by physicians. Primarily, this is an educational procedure since most questionable claims are merely a misunderstanding on the doctor's part. Annually, we have a meeting of the entire Committee for constructive recommendations for the Blue Cross. I would like to personally thank and commend each member of the committee for their devotion to duty.

Recommendations, Reference Committee No. 5

This report was studied and it was noted that there were no issues or action to be taken.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Advisory Commission to Blue Shield

W. Vinson Pierce, M. D., Covington, Chairman

The Advisory Commission to Blue Shield has scheduled a meeting for July 15. A final report will be submitted as an addendum to the Report of the Council on Medical Services.

Addendum to the Report of Advisory Commission to Blue Shield

The KMA Advisory Commission to Blue Shield met this year on July 15, 1965. The purpose and duties of the commission were discussed and the report of the Commission submitted to the 1964 session of the KMA House of Delegates was reviewed. It was noted that the recommendations contained in the report are being implemented.

A very fine presentation concerning Blue Shield activities was presented to the commission by the staff of Blue Shield. There are now over 875,000 Blue Shield members in Kentucky and more than 300 new groups were enrolled this past year. A constant effort is being made to upgrade the program of Blue Shield members.

Your Commission held a very lengthy discussion on the Prevailing Fee Program adopted by the Jefferson County Medical Society earlier this year and put in effect on July 1, 1965. The determination of a prevailing fee schedule is a new concept to study individual physician's fees in a particular community, determine the range of charges that 90% of the physicians in the community charge for specific services, and then to underwrite a program that would pay in full for these services to participating physicians whose fees fall within the 90% range.

Your Advisory Commission to Blue Shield commends the Jefferson County Medical Society and the Kentucky Blue Shield Plan on having initiated this approach and recommends to the Kentucky Medical Association House of Delegates that Kentucky Blue Shield be encouraged to further explore and develop other new methods for providing prepaid medical care.

The members of the Commission were pleased to receive a report on subjects of interest that were presented to the House of Delegates of the AMA in New York during June of this year. Your Commission is following with much interest all matters that effect the providing of medical care. The Advisory Commission will plan to meet as necessary to consider any problems of mutual interest to the Kentucky Medical Association and to Kentucky Physicians Mutual, Inc. which may be referred to it, or which the Commission may feel it advisable to bring it to the attention of either group. To the extent that it is

within the province of the Commission to do so, the Commission will continue to recommend to the House of Delegates of the Kentucky Medical Association the policies which it believes the KMA should adopt on matters affecting the relationship of our state and county medical societies to Kentucky Blue Shield.

Your chairman wishes to express his appreciation to the members of this commission, the Board of Directors and Staff of Kentucky Physicians Mutual Incorporated, the KMA House of Delegates and Board of Trustees, and the officers and staff of KMA for their invaluable assistance and support during this past year.

Recommendations, Reference Committee No. 5

The report was studied in detail and discussion from interested members of the society was heard. We noted that the Advisory Commission to Blue Shield commended the Jefferson County Medical Society and the Kentucky Blue Shield plan on having initiated the prevailing fee schedule and your Reference Committee approves the recommendation of the Advisory Commission and recommends to the KMA House of Delegates that the Kentucky Blue Shield be encouraged to further explore and develop other new methods of providing medical care. The committee approved the report.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Governmental Medical Services Committee

L. F. Beasley, M. D., Franklin, Chairman

The Governmental Medical Services Committee has met twice this Associational year, on November 19, 1964 and May 27, 1965. The committee has been in frequent contact with the Veterans Administration specifically concerning a new Veterans Medical Service Contract. The Veterans Administration has adopted a relative value schedule for payment for Veterans' care. Since this is an apparent wide variation from our former contract a meeting was held in Louisville, November 19, 1964 to discuss this contract.

In the course of this meeting, it was stated by Doctor Van Biesen, the Veterans Administration representative, that there are some 1100 Veterans in the state who are receiving authorized medical care under this contract. He also stated that there are some 500 doctors in the state who are participating in this program and that the maximal number of patients treated by one doctor in any one year was 4 to 6. He also stated that since most major treatments for these Veterans were carried out in the Veterans Hospitals, the number of office and house calls for each doctor engaged in the program was minimal. Our committee voted to recommend that the Board of Trustees adopt the new contract as presented. It in no case lessened the renumeration for services rendered.

At this meeting, we also received a report from the Blue Shield representative on Medicare Contract.

At this initial meeting, the Governmental Medical Services Committee was advised that the Board of Trustees had voted to assign to our committee the duty of studying the various governmental medical programs such as those developed under the Appalachia Program. Since no members of our committee resided in the Appalachia area, it was voted that if the Board did assign such duties to request some additional members to Governmental Medical Services Committee from the area involved. Subsequently, two additional members were appointed to the committee.

The second meeting of the committee was called at the request of the KMA Board of Trustees to specifically consider the subjects of Pediatric and Maternal Clinics and Operation Headstart, both governmental medical programs.

At this meeting, representatives of the Kentucky State Department of Health were guests of the committee and reported on a number of governmental programs involving medical care. A thorough discussion was held by your committee members on these programs which included: (1) Mental Retardation; (2) Maternal Clinics; (3) Pediatric Clinics; (4) High Risk Premature Nursery at the University of Kentucky Medical Center; (5) Migratory Labor Project in Western Kentucky; (6) Health Conservation and Screening, and Visual Conservation and Screening Project; (7) Health Screening Programs in 18 Eastern Kentucky Counties; (8) Accident Study (A reporting study) in Eastern Kentucky; (9) A Proposed Automobile Accident Study Project; and (10) Operation Headstart.

A majority of these matters were discussed for information only. However, specific recommendations were made directly to the Board of Trustees for consideration at their June 3 meeting, at the request of the Chairman of the Board, concerning Operation Headstart and Maternal and Pediatric Clinics.

Concerning Maternal and Pediatric Clinics, the committee members are knowledgeable that the decision to establish such clinics must be approved by the local county medical society. Your committee feels it essential that representatives of the State Department of Health present full and complete information on such clinics to the local county medical society prior to any attempt to establish clinics within a particular county.

At the request of the Board of Trustees, the committee discussed in detail the situation pertaining to Pulaski County, and the committee feels that the problem centered around maternal and pediatric clinics is one of a lack of communications and if the Board of Health sent an appropriate representative to the Pulaski County Medical Society, the problem might be resolved. This committee recommends to the Board of Trustees that KMA go on record supporting this program provided further negotiation is entered into between the State Health Department, the local medical society, and the local pediatricians.

Operation Headstart is a new nation-wide program which involves medicine at the local level. Since KMA had not been made aware of this program or its medical aspects, your committee recommends to the Board of Trustees that a letter be written to the Governor expressing concern over the implications of this state-wide program (Operation Headstart) and state that the Kentucky Medical Association would be happy to serve in an advisory capacity to solve the problems related to this program and that the Governor should request an appropriate person to get in touch with KMA and keep the Association informed.

We further recommend to the Board that included in the letter to the Governor be a request that the medical problems that arise pertaining to the Applachia Program be sent to KMA for their cooperation.

This committee also recommends to the Board that the possibility be explored of using medical students, public health nurses, and other qualified personnel in Operation Headstart to do screening examinations under physician supervision and that those found to have defects be referred to the physician.

The chairman wishes to express his appreciation to the members who have served on this committee during the past year.

COUNCIL ACTION: It is recommended that the report of the Governmental Medical Services Committee be accepted as presented. The Council further recommends that the Board of Trustees take final action on the portion of this report pertaining to Operation Headstart and Maternal and Pediatric Clinics since the Committee met specifically to report this action to the Board.

Recommendations, Reference Committee No. 5

This committee studied this report in detail. It is noted that the council recommended that the report of the Governmental Medical Services Committee be accepted as presented and they further recommended that the Board of Trustees take final action on a portion of this report pertaining to Operation Headstart and Maternal and Pediatric Clinics since the committee met specifically to report this action to the Board. In view of this, your committee was of the opinion that no further action is indicated by this committee and the committee approves the report.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Medicare Review Committee

William H. Powers, M.D., Louisville, Chairman

The Medicare Review Committee was established to review special cases involving more than routine service and fee allowed, submitted under the free Medicare Program, Public Law 569 (Military Dependents' Act.)

Normally this committee meets semi-annually with representatives of Blue Cross — Blue Shield and representatives of the Office of Dependents' Medical Care, Denver, Colorado. The Medicare Review Committee, during the calendar year 1964, reviewed 71 claims which represents 26 fewer claims than were reviewed during the calendar year 1963. During this same period, there were 4,949 claims paid to physicians totaling $345,507.14.

We have continued our policy of distributing these problem claims among the committee members according to their specialty in order that the claims needing review can be considered by the physician in the proper specialty.

Recommendations, Reference Committee No. 5

The committee studied this report and noted there were no issues to be acted upon by the committee at this time.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Insurance Committee

John A. Bishop, M. D., Jeffersontown, Chairman

The Insurance Committee has not met this past year since no matters were referred to it for action. We would like to point out that during the past year, the "simplified Health Insurance Council forms," were revised and in cooperation with the AMA and Health Insurance Council to allow physicians to complete them more easily. Information on obtaining the forms can be had by contacting the KMA Headquarters Office.

Recommendations, Reference Committee No. 5

The committee noted that there were no issues or actions taken by this committee. The committee approved the report.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Mental Health Committee

Logan Gragg, Jr., M. D., Lexington, Chairman

The Mental Health Committee met once during the Association year on Thursday, April 8. It was pointed out that several conferences pertaining to Mental Health were held throughout the country and members of the committee gave reports of those meetings that were attended.

Members of the committee discussed pamphlets and books pertaining to mental retardation and made known the availability of the material to the KMA membership through an article in the Journal.

A major portion of the meeting was devoted to the course of direction and activities the committee plans for the future. Noting that many professional and lay groups have become interested in the mental health field, and money involved for institutions across the state, it was agreed that the committee should interest itself in proper education of professional groups and parents.

It was pointed out that the committee should help disseminate accurate information about mental health by cooperating with the Department of Mental Health and the Kentucky Association for Mental Health. Therefore, it was taken by common consent that a letter be written to the county society secretaries who have not previously appointed mental health chairman, requesting that a mental health committee or a representative be appointed and serve as liaison with the KMA Mental Health Committee.

The chairman wishes to express his appreciation to the members for their interest and participation in committee activities.

Recommendations, Reference Committee No. 5

Your committee studied this report in detail. There were no indications for action to be taken at this time. The committee approved the report.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Sub-Committee on Alcoholism

John C. Keeley, M.D., Owensboro, Chairman

The Kentucky Medical Association's Sub-Committee on Alcoholism did not meet this year. Your chairman wishes to express a desire that this committee be kept as a sub-committee of the Mental Health Committee. Future functioning of the Sub-Committee on Alcoholism will be determined by new developments in this field.

Recommendations, Reference Committee No. 5

Your committee noted that there were no issues taken up by this sub-committee and the committee approved the report.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Placement and Membership

Claude E. Cummins, Jr., M.D., Maysville, Chairman

The Physicians Placement and Membership Committee met on April 29, 1965 with five of the seven members present. A review was made of the use of the Placement Listing and the recommendation of the Board of Trustees that the list be mailed to communities in need of physicians with the permission of the secretary of the county society or if the trustee of the district approves. It was taken by common consent that a community listing, to be sent to doctors seeking locations, be made up, and that before a community is added to the listing we write to the county society secretary asking if the community is definitely in need of additional physicians and if he feels the community should be on the list. It was pointed out that we could use the same letter to the county society secretary to get permission to send a placement listing to the community.

Doctor Cummins read the action of the House of Delegates regarding the Committee's recommendation of establishing annual registration, and it was taken by common consent that this be laid aside for a year. Committee members were given copies of the membership report showing the comparison of 1964 with the first few months of 1965. The members of the Committee believed that this report is informative and should be continued.

There was some discussion regarding the new Orientation program and the fact that it is good

for both doctors from medical school and those coming in from out of state. It was suggested that if a new doctor does not take advantage of the program, more personal contact be made by letter and a follow-up by Mr. Armstrong when he is in the vicinity of the doctor. (This paragraph was referred to Reference Committee No. 2.)

There was considerable discussion regarding the name of the Placement Service and Physicians Placement and Membership Committee. It was the opinion of the members that the name is misleading since we are really more of a Referral Service or Information Service. A motion was made that we recommend to the Board of Trustees that the name of this committee be changed to "Physicians Membership and Placement Information Committee" since our efforts are directed towards providing a two-way flow of information between interested parties rather than in trying to "place" the physician-applicant in the "right" practice situation. Motion passed.

It was taken by common consent that the following statement preface each Placement Listing to avoid confusion as to the role of the Headquarters Office:

> This is a list of physicians who have applied to us for assistance in finding locations. It is our policy to provide a two-way flow of information between interested parties rather than trying to "Place" physicians in the "right" practice situation.

It was taken by common consent that this office should not handle real estate matters, such as office facilities, etc.

The Headquarters staff is to make up as many improved questionnaires as are needed to carry out the Placement Information Service.

There was some discussion regarding sending the Placement Listing to Daniel Boone Clinics. The following 12/12/63 Board action was discussed:

> That the KMA Placement Committee observe the three tenets as enunciated by the Board of Trustees and the House of Delegates, to wit: 1. That the patient has free choice of hospital and physician; 2. That medical service be on a fee for service basis; and 3. That there are no physicians' offices in these hospitals (ARHI).

It was taken by common consent that we recommend to the Board of Trustees that with the changes that have occurred this practice of not sending the Listing be re-studied and all information be uniformly handled.

COUNCIL ACTION: It was recommended that the report of the Placement and Membership Committee be accepted as presented.

The chairman of the Council on Medical Services would like to express his sincere appreciation to the committee chairman, the committee members, and to those who have served on the Council on Medical Services.

COUNCIL ON MEDICAL SERVICES
John A. Bishop, M.D., Jeffersontown
L. F. Beasley, M.D., Franklin
James B. Douglas, M.D., Louisville
Logan Gragg, Jr., M.D., Lexington
Earl P. Oliver, M.D., Scottsville
George W. Pedigo, M.D., Louisville
Claude C. Waldrop, M.D., Williamstown

Recommendations, Reference Committee No. 5

The committee studied this report in detail. There were no indications for action to be taken on this report at this time. The report was approved.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

The preceding reports are a part of the whole.

Mr. Speaker, I move the adoption of the report. (The motion was seconded and carried.)

Report of the Board of Directors of Kentucky Physicians Mutual, Inc.

The Board of Directors of Kentucky Physicians Mutual, Inc., respectfully presents its annual report to the Kentucky Medical Association. It reflects the sixteenth year of operation and service to the people of Kentucky.

As of June 30, 1965, 878,776 people were members of the Plan, an increase of 30,756 over the membership one year ago. In addition, 50,005 persons are now also enrolled in our Extended Benefits program and 15,387 in the Major Medical coverage. During the 12-month period ending June 30, 1965, $9,747,668 was paid to physicians. This is an increase of $489,802 over the previous 12-month period. Calendar year 1965 payments to physicians will approximate 10 million dollars.

The cost of operation for the year ending June 30, 1965, was 10.03% of income. We continue to rank favorably with other Blue Shield Plans with respect to operating cost in that only 9 of the 74 Blue Shield Plans in this country operated at less administrative cost per member than the Kentucky Plan.

During the year the new formula for group rates has proved a stablizing factor. Sufficient additions to reserves have been made to keep the Plan in a sound financial condition. This is highly essential to continued service to the community.

Most important development during the year was the introduction of the "Prevailing Fee" concept. This was brought about by the insistence of one large Jefferson County employer who wanted a plan that would assure full payment for the employees. Briefly, this approach commits the Plan to pay the regular charges for contract benefits of those doctors whose fees are in the lower 90 percentile.

The Blue Shield Board authorized staff to proceed with this in Jefferson County for the Ford Motor Company group. The method was approved by the Jefferson County Medical Society, and under an able Society committee the plan was installed. As it has been in effect only since July 1, no report can be made at this time. If successful, it could well prove a pattern for other areas and be expanded. This method could serve to assure the people of our interest in them and help prevent further encroachment of Government in the provision of medical care.

The thanks of the Board goes to the members of the profession, who by their cooperation have made another successful year for Blue Shield. Special thanks go to the leaders in the Jefferson County Society, who by their long hours of effort made the start of the new program possible. I would also like to add my personal thanks to the Board members, fellow officers and staff for their efforts on behalf of the Plan.

BOARD OF DIRECTORS,
KENTUCKY PHYSICIAN'S MUTUAL
Richard J. Rust, M.D., President

Recommendations, Reference Committee No. 5

This report was studied in detail. There were no recommendations to be made, no action to be taken, the report was approved.

Mr. Speaker, I move the adoption of this report. (The motion was seconded and carried.)

Report of the Rural Kentucky Medical Scholarship Fund

At the 19th annual meeting of the Rural Kentucky Medical Scholarship Fund held on May 27, 1965, a total of 51 new and renewal loans were approved for a total appropriation of $58,500. The Fund in approving these loans now has a record of having

helped a total of 270 students. Four additional loans are still under review—two new and two renewal.

The KMA staff processes all loans and contracts and does the record keeping for the Rural Kentucky Medical Scholarship Fund. A quarterly financial report is submitted to the Board of Trustees of the Fund, which now has $398,000 on loan. Progress reports are secured on students in medical school, and contact is maintained with interns, recipients in the armed services, those in specialty training, and past recipients in practice. Contracts for all plans have been approved as revised, and the brochure has been updated to include the new available plans.

Recipients may choose one of two programs. Under the first plan the applicant may take a loan up to $1300 for which he promises to practice in an area acceptable to the Fund, one year in a rural section for each year he gets a loan. Interest is charged at the rate of two per cent. There were 12 new approved loans under this plan.

The second plan enables the student to borrow up to $2000 a year, provided he contracts to practice in a county where there is a critical shortage of physicians. For each year that he practices in one of these counties his loan will be waived. One new application was approved for this loan.

Of the renewal applications, 10 are seniors, 11 are juniors, and 7 are sophomores. In the 1965-66 school year the recipients will attend the following medical schools: University of Kentucky 24; University of Louisville 12; Tulane 2; Howard 1; Meharry 1; Vanderbilt 1. Fourteen will be interning and 11 will be fulfilling military obligations. We now have 126 recipients practicing in 78 counties.

The critical counties this year are: Martin, Owsley, Magoffin, Elliott, Leslie, Knott, Breathitt, Powell, Wolfe, and Jackson. Two of these counties, Magoffin and Elliott, will be served by Scholarship recipients, starting this year. During the year three Scholarship recipients who have established practice in the critical counties will be relieved of their financial obligations, having served the required time in these needy areas.

A new feature of the plan became effective this year with the provision of $2000 that would help a young physician become established in one of the critical counties. Under this plan, for each year that a doctor stays in the county $500 of the loan will be cancelled. One recipient under this plan will establish practice in Salyersville, Magoffin County.

The Board of Trustees of the Rural Kentucky Medical Scholarship Fund approved the recommendation of its Postgraduate Committee that there be no additional specialties added to the list of approved residencies. The present approved list includes: anesthesiology, radiology, pathology, pediatrics, internal medicine, family and general practice, ophthalmology, and ENT.

The Board of Trustees is especially appreciative of the continuous interest and support given by Governor Edward Breathitt and the General Assembly of the Commonwealth of Kentucky, and Russell E. Teague, M.D., Health Commissioner.

Rural Kentucky Medical Scholarship Fund
C. C. Howard, M.D., Chairman,
Board of Trustees

Recommendations, Reference Committee No. 5

The report was studied as a whole. This Reference Committee would like to point out the evidence in this report showing the positive steps on the part of medicine to distribute medical care to the needy areas. The committee noted that the recommendation of the post-graduate committee was approved by the Board of Trustees of the Rural Kentucky Scholarship Fund that no additional specialists be added to the ranks of approved residencies, which include Anesthesiology, Radiology, Pathology, Pediatrics, Internal Medicine, Family and General Practice, Opthalmology, and ENT. The report was approved.

Mr. Speaker, I move the adoption of this report. (The motion was seconded.)

During the discussion of this portion of the reference committee report, the following amendment was made by Paul Maddox, M.D., Wolfe County:

> Beginning with the year 1966 the Kentucky Medical Association recommend to the Rural Scholarship Fund that all students who receive assistance from the Kentucky Rural Scholarship Fund either in the form of grants or loans be obligated to fulfill their obligation to the fund by practicing in a critical county.

The amendment was seconded and carried.

The motion on the adoption of the report as amended carried.

Report of the KMA Technical Advisory Committee on Indigent Medical Care

Medical Care, Public Assistance, and Medical Assistance to the Aged

The state spent 12.8 million dollars during the past fiscal year for services provided the 120,000 of its citizens who participated in one of these programs. This is an average of approximately $107.00 per person receiving care. Per patient Nursing Home care averaged $920.00; hospitalization, $234.00; drugs, $30.00; and physician and dentist services together averaged $20.00.

Sixty-two per cent of those eligible participated to some extent in this program. The PAA section is relatively constant in number, but the total number of those eligible for MAA services is still unknown. During this year, there were 25,000 who received aid—the total number is estimated at some figure from 80,000 to 120,000—many persons in this age group who probably are eligible do not apply for services until there is need, and since many of them have had no occasion to request services, their eligibility status is unknown.

It is contemplated that the Medicare program—which at the date this report is written is in House-Senate Conferences—will materially influence these programs, but until the regulations, eligibility data, etc., is in its final form, no accurate appraisal is possible. It is, however, expected that at least 20,000 families will be eligible to participate in a new category of aid to dependent children, whose wage earner is unemployed.

There have been two sessions of the governor's Advisory Council to the Medical Care Programs, and efforts are still being made to simplify the vendor's invoices for services rendered the program, and also the prescription forms. Three agencies in the State Government are interested in these matters —the Department of Economic Security, the Department of Health, and recently the Department of Finance. A great deal of time and energy has been spent in an effort to secure these concessions, but so far, they have not been fruitful.

As taxpayers, and vendors of services to many of these of our neighbors, we should remain active in these programs, and even though we are not wholeheartedly in agreement with many of their provisions, we must participate, and above all try to influence their course in a direction which will be least destructive to private medicine.

KMA Technical Advisory Committee On Indigent Medical Care

Claude C. Waldrop, M.D., Williamstown, Chairman
Owen Davis, M.D., Scottsville
George E. Estill, M.D., Maysville

Paul F. Maddox, M.D., Campton
Carroll H. Robie, Jr., M.D., Louisville
Harold Schupbach, M.D., Owensboro

Recommendations, Reference Committee No. 5

This committee studied this report in detail. This committee accepted this report with the exception of page 2, last paragraph, line 4. Substitute the words "provide medical care" for the word "participate." This would then read:

As taxpayers and vendors of services to many of these of our neighbors, we should remain active in these programs. Though we are not wholeheartedly in agreement with many of their provisions, we must provide medical care and above all try to influence their course in a direction which will be least destructive to private medicine. Mr. Speaker, I move the adoption of this report as amended. (The motion was seconded and carried.)

Report of the Advisory Committee to Selective Service

The past year has been a rather busy one for this Committee, particularly the latter half of the Associational year. This was due to the increase in demand for Medical officers, the present world situation made it necessary for us to have an increased quota to fill this year.

The Committee met during the Interim Meeting at Owensboro and had as our guests representatives of the Selective Service office at Frankfort. We adopted the policy of adhering to the regulations issued by the Selective Service Headquarters in Washington. Several distressed areas in the State were taken care of by deferring some men finishing their internship. Others, where the need was not so great, could not be taken care of unless physicians out in practice were to be called to active duty. So far, this undesirable action has not been necessary.

We have had excellent cooperation on the part of Colonel Everette Stephenson and Colonel Marshall Sanders and are indebted to the Headquarters staff of the KMA for much basic information required by the Committee.

Advisory Committee To Selective Service
J. Duffy Hancock, M.D., Louisville, Chairman
Glen U. Dorroh, M.D., Lexington, Vice-Chairman
James Archer, M.D., Paintsville
Charles B. Billington, M.D., Paducah
O. B. Coomer, D.D.S., Louisville
Sidney G. Dyer, M.D., LaCenter
Sam A. Overstreet, M.D., Louisville
Marcus R. Randall, D.D.S., Louisville
L. S. Shirrell, D.V.M., Frankfort
Russell E. Teague, M.D., Frankfort
L. O. Toomey, M.D., Bowling Green
Celestia Uftring, R.N., Louisville

Recommendations, Reference Committee No. 5

This report was studied. There were no issues to be acted upon. The report is approved.

Mr. Speaker, I move the adoption of this report. (Motion seconded and carried.)

Report of the Representative Kentucky Mental Health Planning Commission

During the year 1964-65 the Kentucky Mental Health Planning Commission completed its third year of the study of Kentucky's Mental Health Resources and needs. The Commission had been appointed at the end of Governor Comb's administration and had been financed by a grant from the National Institute of Mental Health. Governor Breathitt added several members to the Commission. During the past year, the Commission has appointed a number of task forces to study specific problems. The principle committees were study groups on special facilities for children; secondly, on facilities for adult services and thirdly, for prevention and education in the field of mental health. A large number of members of the Kentucky Medical Association have served on various sub-committees and have helped materially in the planning process.

The final report is now in the process of being written and it is anticipated will be presented to the Governor shortly after the first of July 1965, when the term of the Commission expires.

Briefly, the report surveys the history of the mental health movement in Kentucky, records the statistical outline of the present problem of resources for the mentally ill in Kentucky and makes some general recommendations toward setting up regional mental health boards under community leadership. It is recommended that these boards undertake the setting up of community mental health centers to provide treatment, preventive services and education services throughout the state.

Frank M. Gaines, M.D., KMA
Representative, Kentucky Mental Health Planning Commission

Recommendations, Reference Committee No. 5

This report was studied. There were no issues for action, no recommendations. The report was approved.

Mr. Speaker, I move the adoption of this report. (Motion seconded; carried.)

Resolution A
Fayette County Medical Society

WHEREAS, there have been recent unsuccessful attempts by certain elements of government, the American Hospital Association, the AFL-CIO and others to draw some segments of the medical profession, namely pathologists, radiologists, anesthesiologists and physiatrists into a Social Security financed scheme of medical care, and

WHEREAS, these attempts came about because of the widespread established practice of interlocking administration and financial arrangements between those specialties and hospitals, and

WHEREAS, continuation of such relationships can too easily lead to control of all of the Medical Profession with resulting detriment to patient care, and

WHEREAS, this interlocking relationship has created inflated costs in some hospital departments in order to subsidize other hospital functions, and

WHEREAS, experience has shown that professional fees in these areas can be and have been reduced and the quality of professional services improved when such subsidization of one hospital department by another is abandoned, and

WHEREAS, it is recognized that hospital operating costs are high and that hospitals cannot suffer decrease in gross income, *NOW THEREFORE BE IT*

RESOLVED, it is in the public interest and in the interest of the whole Medical Profession that arrangements to provide patient care by the in-hospital specialists be such that directors of these Medical Facilities be unhampered by third party intervention, *AND BE IT FURTHER*

RESOLVED, that since the practice of these specialties constitutes direct patient care, the financial arrangements and all decisions regarding such medical practice should be as direct as with other physicians and should be the prerogative of the physician-directors of these departments, *AND BE IT FURTHER*

RESOLVED: that these physicians should bill separately from the hospital for their services and

that they should be reimbursed for their services by the same agencies (insurance-carrier or otherwise) who reimburse other physicians rather than by or through a hospital, *AND BE IT FURTHER*

RESOLVED, that with the institution of such Specialist-Hospital arrangements attempts should be made by these specialists to reduce costs to the patient, *AND BE IT FURTHER*

RESOLVED, that hospitals be urged to conduct cost studies so that sources of costs to the patient can be identified and that each department carry its fair share of these costs with elimination of disproportionate subsidization by some departments and services.

Recommendations, Reference Committee No. 5

This committee studied this report, heard considerable opinions from interested members of the society, and after careful consultation states the committee is in favor of the principal involved in this resolution; that is,

(a) Separation of services,
(b) Direct billing,
(c) The referral that specialists enumerated in the report be considered as private practitioners of medicine.

The committee further agrees that the material in this resolution requires further detailed study. This committee recommends that this study be made by the Board of Trustees and further recommends the formation of a Liaison group with the various medical specialties and hospital facilities involved and further that this group act with expediency to work out the problems.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Resolution B

Garrard County Medical Society

WHEREAS, the Veterans Administration in Louisville has recently written to patients suggesting that prescriptions to be filled be mailed to their Pharmacy Out-Patient Clinic in place of the local pharmacist unless it is an emergency or delay in receipt of medicine.

WHEREAS, they list the reason for this that it is to the advantage of the government to fill long term prescriptions for veterans.

WHEREAS, the only way it could be an advantage would be that of being slightly cheaper. But by the time they use the taxpayer's money, hire a pharmacist, clerical help, etc., this probably would be no advantage.

WHEREAS, that such practice is another inroad by the government to take over the private practice of pharmacy and curb private enterprise and freedom of practice.

BE IT THEREFORE RESOLVED, that K.M.A. go on record as strongly opposing such letters being sent to patients and the V.A. filling prescriptions rather than private drug stores, and be it further resolved that if it isn't stopped that the physicians of K.M.A. refuse to participate in the Veterans Out-Patient Medical Clinic Program.

Recommendations, Reference Committee No. 5

This committee studied this resolution and makes the following recommendation as to change. The last paragraph reads:

BE IT THEREFORE RESOLVED, that K.M.A. go on record as strongly opposing such letters being sent to patients and the VA filling prescriptions rather than private drug stores, and be it further resolved that if it isn't stopped that the physicians of K.M.A. refuse to participate in the Veterans Out-Patient Medical Clinic Program.

The recommended change should read as follows:

BE IT THEREFORE RESOLVED, that K.M.A. go on record as strongly opposing such letters being sent to patients and, when feasible, use of private pharmacies encouraged.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded; carried.)

Resolution G

J. E. Stephenson, M.D., Delegate, Boyd County Medical Society

WHEREAS, increasingly difficult problems confront us individually and as a group. We know that ignoring the problem or piece meal solutions are inadequate. Only a consideration of the problem of medical services as a whole will point up the desired solution and the direction our thoughts should take.

WHEREAS, you are knowledgeable and literate men, individualists with initiative and self reliance, qualified by virtue of education, training and experience in the area of health needs and care and the admitted experts in this field.

WHEREAS, those who presently seem to hold our destiny in their hands at best have a superficial and slanted view of the problem.

WHEREAS, in the larger framework of our democratic society we are permitted redress.

WHEREAS, it would be tragic if we by poor judgment and poorly considered acts should do to ourselves within what those without attempt to do.

WHEREAS, many feel our present position is complicated, complex and the solution is elusive. *BE IT THEREFORE*

RESOLVED, the problem may be viewed in terms of reference to a solution, thus ideally permitting cross checking in minute detail so that error is not made.

RESOLVED, that our problem in terms of a solution requires an accommodation of views and opinions among ourselves in a medical forum in preference to a political forum.

RESOLVED, that the (1) free and unfettered practice of medicine, (2) the free choice of physician and hospital by the patient, (3) the maintenance of the privacy of the doctor-patient relationship, & (4) the fee for service concept are fundamental principles in the practice of medicine.

RESOLVED, that individuality, initiative, self reliance and the free expression of views and opinions must be guaranteed.

RESOLVED, that it reasonably follows, we should have an open mind to the needs, desires and wishes of those who buy our services and accord their individuality, desire for security and freedom of equal value with our own.

RESOLVED that we must cease to appear in the public mind as a special interest group. Our welfare depends on the welfare of our patients and there is a direct and reciprocal relationship.

RESOLVED, that we are opposed to a monolithic system of medical services under the control of a third party which plays a dominate role in the doctor-patient relationship.

RESOLVED, that a third party such as an insurance company which is responsive to the wishes of the doctor and patient and has a supportive role, is not a foe, but a valued friend.

RESOLVED, that these three groups, the doctor, the patient and the insurance industry are the only ones that conceivably should be involved in planning remedies and constructive final action.

RESOLVED, that this group (House of Delegates) is an ideal forum for such a study to provide our component county societies with guidelines for planning to ensure order and eliminate errors.

RESOLVED, that the county society is the reasonable level at which initiative should be taken and a plan if desired can be tailor-made to the county

society needs and desires and the local community needs and desires.

RESOLVED, that we individually have professional and business competence and these reasonably can be applied to group planning and action.

RESOLVED, that this concept is the opposite to a monolithic third party type plan, and can be done outside the framework of government or taxation. It not only preserves individuality, initiative and the free expression of views and opinions but enhances them. It equates our patient's interest and welfare as being of equal value with our own. It would be flexible, permit modification and permit participation or non participation.

RESOLVED, that this resolution is a basic study and contains in it guidelines for planning community medical services.

Recommendations, Reference Committee No. 5

The committee studied this very erudite and philosophical report which brings out many important phases of the problems medicine faces today. Your committee approves the principles of this report and is of the opinion that no action on the part of the Kentucky Medical Association is necessary.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded, carried.)

Resolution K

Rowan County Medical Society

WHEREAS, there have been many medical facilities constructed under the Hill-Burton Act with public funds, and many of these installations have been turned over to private groups, and

WHEREAS, such private groups have the legal status of "private" and the "private" medical facility has been removed from all other control, and

WHEREAS, some of these "private" facilities have made arrangements with the Medical Department of the University of Kentucky Medical Center whereby medical students are used as physicians, both in the emergency room and on the ward, frequently with no supervision at all, and

WHEREAS, some of the facilities staffed by the students are non-accredited hospitals and are using the medical students as physicians and charging for these services, NOW THEREFORE BE IT

RESOLVED, it is in the public interest that facilities constructed with public funds be given the legal status of "public", *AND BE IT FURTHER*

RESOLVED, that there be no students from the medical schools staffing any non-accredited hospital, *AND BE IT FURTHER*

RESOLVED, that the patient be notified that the student giving treatment in any instance be identified as a student, *AND BE IT FURTHER*

RESOLVED, that there be no fee charged or recieved for any treatment offered by a student, *AND BE IT FURTHER*

RESOLVED, that the curriculum of the medical students be studied to determine the proper use of the student, his time and his relation to the private practice of medicine both in and outside of the hospital.

Recommendations, Reference Committee No. 5

This resolution was studied and the committee heard considerable discussion from interested members of the Kentucky Medical Association. After careful consideration, your committee recommends that this Resolution K be referred to Council on Medical Education and Hospitals for the purpose of establishing guidelines that should be followed in the use of medical students in the hospitals.

Mr. Speaker, I move the adoption of this report. (The motion was seconded and carried.)

Mr. Speaker, I move the adoption of Reference Committee No. 5 as amended as a whole. (Motion seconded; carried.)

Reference Committee No 5
Louis M. Foltz, M.D., Louisville, Chairman
W. Vinson Pierce, M.D., Covington
James L. Ferrell, M.D., Paris
David A. Hull, M.D., Lexington
J. E. Stephenson, M.D., Ashland

REFERENCE COMMITTEE NO. 6†

Douglas H. Jenkins, M.D., Chairman

Reports on Constitution and Bylaws; Special Committees

†See note (†) bottom of column 1, page 972.

Reference Committee No. 6 considered the following reports:

17. Advisory Committee to the Editor
18. Judicial Council
19. Committee on Third Party Medicine
20. Committee to Study the Constitution and Bylaws
21. Interim Meeting Program Committee
22. Insurance Review Board

Report of the Advisory Committee to the Editor

During the 1964-65 Associational year, your committee held one meeting with the editors.

The committee heard a report on the actions that have been taken by the Editors and staff to implement previous recommendations this committee has made. The committee felt the evidence of performance was entirely satisfactory.

Your committee feels that the new plan of distributing journals to medical students through the libraries of the medical schools is far less expensive and is acceptable to the student. The old method of trying to follow all the changes of addresses of student subscribers was ineffective, costly and time consuming.

Your committee would again urge the county medical society to submit the minutes of their meetings each month for publication in The Journal. This enables other county societies to keep up with their neighbors and serves as a stimulus to more productive meetings.

Reports indicate that there is room for "cautious optimism" for an increase in advertising revenue from national accounts in the year ahead. The State Medical Journal Advertising Bureau, the agency that secures our advertising, has been reorganized; new personnel and new methods are being employed. Already, there has been improvement.

The Journal of KMA stood second of the thirty-four member journals of the SMJAB in percentage of increased advertising for the first six months of 1965. This would seem to indicate the faith our advertisers have at this time in our publication.

Nominations for eight new members to serve on the Board of Consultants on Scientific articles for a three-year period were approved. Consideration was given to a possible change in the front cover page of The Journal. All members present agreed that the present cover page was quite appropriate and distinct and it was decided to recommend no changes at this time.

Other matters considered by your committee included reviewing of the 1965 special issue, plans for the 1966 seminar number, possible changes in the format for the annual meeting issue and representation at the biennial medical editors' conference this October 23-24.

The committee members expressed their apprecia-

tion to the Editors for the splendid service they are rendering the profession as a result of their work on The Journal.

Advisory Committee To The Editors
Blaine Lewis, M.D., Louisville, Chairman
Patrick J. Murphy, M.D., Lebanon Junction
Gerald B. Reams, M.D., Ashland
Willett H. Rush, M.D., Frankfort
Frederick Scott, M.D., Madisonville
Orson P. Smith, M.D., Louisville

This report was studied in detail and the committee made notes of the following:

1. The performance of the editors and staff was entirely satisfactory.
2. The plan of distributing Journals to the students in medical schools through the libraries at the medical schools is far less expensive and is acceptable to the students.
3. The county medical societies are urged to submit their minutes of the meetings each month for publication in The Journal.
4. There is expected an increase in advertising revenue from the national accounts in the year ahead. The State Medical Journal Advertising Bureau, the agency that secures our advertising, has been reorganized, new personnel and new methods are being employed.
5. The nominations for eight new members to serve on the Board of Consultants for scientific articles for a three-year period were approved.
6. Other matters reported by the Advisory Committee included reviewing of the special issue, plans for the 1966 seminar number and possible changes in the format for the Annual Meeting issue.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Judicial Council

Background

The KMA House of Delegates, at its 1964 meeting, acknowledged the need for a Judicial Council and very wisely passed the By-law (Chapter VII) creating such a council. In doing so, another progressive step was taken toward strengthening the structure of organized medicine in Kentucky.

Through the ages, the physician has generally held an enviable place in society because he has disciplined himself to live and practice within the ethical framework of honor, respect, and dignity in his dealings with patients, his fellow physicians, and with the public. However, in certain instances, problems arise which involve ethics, right and standing of KMA members, censorship, and violations of the Medical Practice Act, which demand special consideration and action. It is to this end that the Judicial Council serves a specific purpose.

Proceedings

Since its creation the Judicial Council has held three sessions on a quarterly basis. At its first meeting, 28 January 65, the By-laws specifically relating to the Council were carefully reviewed, and a plan for the development of operational procedures was initiated. In addition, certain complaints and grievances were duly considered and acted upon. In the two subsequent meetings the following operational procedures were adopted:

(a) Agreement of Waiver
(b) Manual on Grievance Procedures

The latter is designed to aid the County Society Grievance Committees, the individual trustee and district grievance committees in following an orderly disposition of complaints made against member physicians. Due to its length, it is included in this report by title only. It is, however, at all times available to those who have need for its use. It will be routinely distributed to the county societies and trustees responsible for the adjudication of grievances. Because it is strongly felt by the Judicial Council that grievances can be best resolved at the local level, every effort should be made at this level to do so. Complete reports of any grievance considered by the county society grievance committee, trustee or district grievance committee should be forwarded to the Judicial Council for its information.

A questionnaire was sent to all county society secretaries requesting pertinent information regarding the activities and composition of their grievance committees. It is essential that the Council have this information in order to properly process any grievance brought to its attention.

By-Law Change

In order to conform with the second paragraph, Section 10, Chapter XII of the By-laws, the Judicial Council recommends that the following change be made in the second paragraph, Section 8, Chapter VII, to read:

"If the district grievance committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall be entitled to be represented by counsel, to present the testimony—etc.—provided."

Types of Complaints Considered by the Judicial Council to Date

(a) Patient vs Physician
(b) Patient vs Hospital
(c) Physician vs Physician
(d) Satellite Practice
(e) Division of Fees Among Group of Physicians

Many grievances could be averted if the parties involved would be willing to take time for adequate communication, make a sincere effort to try to understand the other side of the question, and last but not least, live by the Golden Rule.

KMA Judicial Council
N. Lewis Bosworth, M.D., Lexington, Chairman
Henry B. Asman, M.D., Louisville
J. Duffy Hancock, M.D., Louisville
Hugh Houston, M.D., Murray
Clyde C. Sparks, M.D., Ashland

This reference committee reviewed the excellent report of the newly formed Judicial Council. The Council reported their purposes, and acted on complaints and grievances.

The Judicial Council had reviewed the Bylaws relating to the Council and adopted the following operational procedures: a) agreement of waiver; and b) manual on grievance procedures.

Completed reports of any grievance considered by the county society grievance committee, trustee or district grievance committee should be forwarded to the Judicial Council for information. It is essential that the Council have this information in order to properly process any grievance brought to its attention.

The Judicial Council recommends that the following change be made in the second paragraph, Section 8, Chapter VII, to read:

"If the district grievance committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall be entitled to be represented by counsel, to present the testimony—etc.—provided."

Mr. Speaker, I move the adoption of this section of the report. (The motion seconded; carried.)

Report of the Committee on Third Party Medicine

Problems in regard to Third Party Medicine have not been presented or referred to this Committee since the last session of the House of Delegates. For this reason, our Third Party Committee did not have a meeting.

Although our Third Party Committee has been inactive during the past year, it is recommended that this Committee be continued and stand ready for any Third Party problem which may arise.

COMMITTEE ON THIRD PARTY MEDICINE
John C. Harter, M.D., Louisville Chairman
Walter L. Boswell, M.D., Lexington
Ballard W. Cassady, M.D., Pikeville
Robert Jasper, M.D., Somerset
Robert E. Norsworthy, M.D., Hartford

Recommendations, Reference Committee No. 6

This reference committee noted there have been no major problems reported to this committee since the last session of the House of Delegates and the Third Party Committee did not have a meeting. It was recommended that the committee be continued and stand by for any problems that arise.

The reference committee thinks that the Third Party Medicine Committee is potentially a very important committee and should be fully utilized in the future.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Committee to Study the Constitution and Bylaws

Your committee held one meeting during this Associational year, on June 16, to continue its study of the KMA Constitution and Bylaws and to implement any matters that had been referred to it by the House of Delegates and Board of Trustees.

Chapter XII, Section 4 of the Bylaws

The 1964 session of the House of Delegates approved a recommendation that the Bylaws be amended so Section 4, Chapter XII be eliminated in so much as this section refers to the issuance of charters to organizations of Negro physicians outside of the county medical societies.

Chapter XII, Section 4 of the Bylaws now reads as follows:

"Only one component society shall be chartered in any county except that the House of Delegates may issue a charter to one statewide society of worthy Negro physicians who are not members of any component society. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky Medical Association."

The committee proposes that this section of the Bylaws be amended as follows:

"Only one component society shall be chartered in any county. Membership in the component society thus created shall entitle the member thereof to all the rights and benefits of membership in the Kentucky Medical Association.

Recommendations, Reference Committee No. 6

1. Chapter XII, Section 4 of the Bylaws. The 1964 session of the House of Delegates approved a recommendation that the Bylaws be amended so Section 4, Chapter XII be eliminated in so much as this section refers to the issuance of charters to organizations of Negro physicians outside of the county medical societies.

Chapter XII, Section 4 of the Bylaws now reads as follows:

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The Committee proposes that this section of the Bylaws be amended as follows:

"Only one component society shall be chartered in any county. Membership in the component society thus created shall entitle the member thereof to all the rights and benefits of membership in the Kentucky Medical Association.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Chapter I, Section 2-e (Student Membership)

It is currently the policy of the House of Delegates that there be no more student memberships at the rate of $4 for four years, but that a package of KMA Journals be made available each month to interested students in each of Kentucky's medical schools through the librarian.

Chapter 1, Section 2 (e) of the Bylaws now reads as follows:

"(e) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. Student members shall receive The Journal of the Association. The membership year for student members shall run from September 1 to August 31 of each year."

The committee suggests that next year's Bylaws Committee review this section again with the possibility in mind of deleting the entire section. The committee recommends that the 1965 House of Delegates delete the following sentence from Chapter I, Section 2 (e) of the Bylaws:

"Student members shall receive the Journal of the Association."

Recommendations, Reference Committee No. 6

2. Chapter I, Section 2-e (Student Membership). It is currently the policy of the House of Delegates that there be no more student memberships at the rate of $4 for four years, but that a package of KMA Journals be made available each month to interested students in each of Kentucky's medical schools through the librarian.

Chapter I, Section 2 (e) of the Bylaws now reads as follows,

"(e) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. Student members shall receive The Journal of the Association. The membership year for student members shall run from September 1 to August 31 of each year."

The committee suggests that next year's Bylaws Committee review this section again with the possibility in mind of deleting the entire section. The committee recommends that the 1965 House of Delegates delete the following sentence from Chapter I, Section 2 (e) of the Bylaws:"

"Student members shall receive The Journal of the *Association."*

The reference committee feels that a more active program for student participation in organized medicine should be carefully reviewed before the suggested deletion of student memberships.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Chapter I, Section 5

The committee felt that Chapter I, Section 5 of the Bylaws needed clarification in that many members feel that the provisional status for new members is for the entire two years even though a member may have completed the orientation course, and also that he is not entitled to full privileges of active membership in the Association.

Chapter I, Section 5 of the Bylaws now reads as follows:

"Every active member shall occupy a provisional status for two years immediately following his admission to membership in the Association, during which period he must successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees. The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within the two-year period shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component county society."

In order to clarify the above mentioned problem, your Constitution and Bylaws Committee recommends that Chapter I, Section 5 be revised to read as follows:

"Every new active member shall be required to attend and successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees. The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within two years after the member is first admitted to active membership shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall therefore, for a period of one year, be ineligible for membership in any component society."

Board of Trustees Action on Report of Committee to Study the Constitution and Bylaws

This report was reviewed by the Board of Trustees on August 5, 1965.

BOARD ACTION, Approved with the recommendation that the following phrase be added to the proposed amendment to Chapter I, Section 5, on page 3 of the committee report: " . . . and shall not after one year be admitted to membership unless and until he has successfully completed the required orientation course."

Recommendations, Reference Committee No. 6

3. Chapter I, Section 5. The committee felt that Chapter I, Section 5 of the Bylaws needed clarification in that many members feel that the provisional status for new members is for the entire two years even though a member may have completed the orientation course, and also that he is not entitled to full privileges of active membership in the Association.

Chapter I, Section 5 of the Bylaws now reads as follows:

"Every active member shall occupy a provisional status for two years immediately following his admission to membership in the Association, during which period he must successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees. The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within the two-year period shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component county society."

In order to clarify the above mentioned problem, your Constitution and Bylaws Committee recommends that Chapter I, Section 5 be revised to read as follows:

"Every new active member shall be required to attend and successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees. The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within two years after the member is first admitted to active membership shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component society."

Bottom Addendum of the Report of the Constitution and Bylaws Committee to the 1965 Session of *the House of Delegates.* The Board of Trustees approved the amendment with the recommendation that the following phrase be added to the proposed amendment to Chapter I, Section 5 on page 3 of the committee report: *". . . and shall not after one year be admitted to membership unless and until he has successfully completed the required orientation course."*

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Chapter VIII, Section 4

The committee discussed Chapter VIII, Section 4 of the Bylaws in which it states that the KMA will be the Headquarters for all committees and councils. The committee members feel that all KMA committees and councils should schedule their meetings through the headquarters office so there will be a record of the meeting even though it is not necessary that all meetings be held in the headquarters office.

The last sentence in the first paragraph of Chapter VIII, Section 4 now reads as follows:

"The Headquarters Office shall be the headquarters for all committees and councils, unless otherwise specifically ordered by the Board of Trustees or its Executive Committee."

Your committee recommends that this sentence be revised to read as follows:

. . ."The headquarters office shall be the headquarters for all committees and councils, unless otherwise specifically ordered by the Board of Trustees or its Executive Committee, and all notices of committee meetings shall issue from the headquarters office at the direction of the chairman."

COMMITTEE TO STUDY THE CONSTITUTION AND BYLAWS

Robert S. Dyer, M.D., Louisville, Chairman
John S. Baughman, III, M.D., Harrodsburg
Matthews C. Darnell, Jr., M.D., Lexington
W. Bruce Hamilton, M.D., Shepherdsville
Douglas H. Jenkins, M.D., Richmond
James G. Sills, M.D., Hardinsburg

Recommendations, Reference Committee No. 6

4. Chapter VIII, Section 4. The last sentence in the first paragraph of Chapter VIII, Section 4 now reads as follows:

"The Headquarters office shall be the headquarters for all committees and councils, unless otherwise specifically ordered by the Board of Trustees or its Executive Committee."

The Constitution and Bylaws Committee feels that all KMA committees and councils should schedule their meetings through the headquarters office so there will be a record of the meeting even though it is not necessary that all meetings be held in the headquarters office. The Constitution and Bylaws Committee recommends that Chapter VIII, Section 4 be revised to read as follows

"The Headquarters Office shall be the headquarters for all committees and councils, unless otherwise specifically ordered by the Board of Trustees or its Executive Committee, and all notices of committee meetings shall issue from the Headquarters office at the direction of the chairman."

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

The following amendment to the KMA Bylaws has been recommended by the Judicial Council, endorsed by the Board of Trustees and approved by the Constitution and Bylaws Committee. It is recommended that the second literary paragraph of Section 8, Chapter VII, be amended to harmonize with Section 10, Chapter XII in the Bylaws by permitting the parties to be represented by counsel, as follows:

"If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee, shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall be entitled to be represented by counsel, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided."

Recommendations, Reference Committee No. 6

5. Addendum to the Report of the Constitution and Bylaws Committee to the 1965 Session of the House of Delegates. The following amendment to the KMA Bylaws has been recommended by the Judicial Council, endorsed by the Board of Trustees and approved by the Constitution and Bylaws Committee. It is recommended that the second literary paragraph of Section 8, Chapter VII, be amended to harmonize with Section 10, Chapter XII in the Bylaws by permitting the parties to be represented by counsel, as follows:

"If the District Grievance Committee's investigation indicates that the members may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall be entitled to be represented by counsel, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided."

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion seconded; carried.)

Report of the Interim Meeting Program Committee

The 1965 Interim Meeting was held in Owensboro on March 18. The program, which featured five nationally known guest speakers, was well received. Reprint requests on a number of the talks made at the meeting were received and processed.

Your committee met late in the fall of 1964 at Gabe's Restaurant in Owensboro and gave full consideration to the matter.

While attendance at the meeting was slightly better than average, some observers felt the special "open" meeting of the House of Delegates, which was a very fine meeting, caused some loss of attendance at the Interim Session.

Our committee wishes to express its appreciation to the members of the Daviess County Medical Society and all others who contributed to the success of our 1965 Interim Meeting.

INTERIM MEETING PROGRAM COMMITTEE

Delmas M. Clardy, M.D., Hopkinsville, Chairman
W. Gerald Edds, M.D., Calhoun
William W. Hall, M.D., Owensboro
Robert E. Pennington, M.D., London

Recommendations, Reference Committee No. 5

The committee reviewed the report of the Interim Meeting Program Committee.

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion seconded; carried.)

Report of the Insurance Review Board

Actually there has been no genuine indication for a formalized meeting of this committee during the course of the year and as such, it has not been called.

Several minor matters of physician release for medical and hospital records for insurance purposes have come up for review, but these were all settled amicably and without undue problems to either side. There have been no actual formalized complaints by the insurance representatives or physicians to members of this committee as far as I know.

An item of new business to be considered possibly for next year has been one presented by a doctor in Columbia, Kentucky and others, is related to insurance forms themselves.

The age-old problem of the multiplicity of insurance forms has been brought up again and probably some definite action should be taken toward adoption of the provided standard report forms.

Another complaint along these lines has been the necessity to fill out a weekly insurance report to several minor companies. The complaints have indicated that this is a genuine nuisance and possibly through committee action, we could do something about it. No formal action, of course, has been taken on these last two paragraphs, but it's something that possibly is worth consideration and a committee meeting in the coming year.

INSURANCE REVIEW BOARD

W. C. Mitchell, M.D., Louisville, Chancellor
Bernard J. Baute, M.D., Lebanon
Jack L. Chumley, M.D., Louisville
Harvey Chenault, M.D., Lexington
John Dickinson, M.D., Glasgow
Albert S. Irving, M.D., Louisville
Paul H. Klingenberg, M.D., South Ft. Mitchell

Recommendations, Reference Committee No. 6

We studied the report of the Insurance Review Board in reference to matters of physician release of medical and hospital records for insurance purposes and the problem of multiplicity of insurance forms but no definite action was taken toward the adoption of this section of the report.

This committee recommends that the Insurance Review Board proceed with their efforts to provide a simplified standard insurance form.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

As Chairman, I would like to express the appreciation of this committee for their diligence and dedicated work on the committee.

Mr. Speaker, I move the adoption and implementation of this report as a whole. (Motion was seconded and carried.)

REFERENCE COMMITTEE NO. 6

Douglas H. Jenkins, M.D., Richmond, Chairman
Leroy C. Hess, M.D., Florence
Irving Kanner, M.D., Lexington
Joseph R. Miller, M.D., Benton
Henry W. Post, M.D., Louisville

REFERENCE COMMITTEE NO. 7†

Sam Weakley, M.D., Chairman

Miscellaneous Reports

† See note (†) bottom of column 1, page 972.

The reports this reference committee considered are as follows:

25. Report of the McDowell Home Committee

26. Memorials Commission

28. KMA Representative to Conference of Presidents and Other Officers of State Medical Associations

29. KMA Representative, University of Kentucky Chapter Student AMA

30. KMA Representative, University of Louisville Chapter Student AMA

Report of the McDowell Home Committee

In the past year, the McDowell Home Committee has met on three occasions in the Home in Danville. The Home is in excellent repair at this time and continues to represent a distinguished landmark in Kentucky medicine, is a credit to the profession, acts as a great stimulus to young and old in the unrivaled heritage of Medicine, and stands on its own merit in public relations. During the year, various groups, both medical and non-medical, have visited the Home. These included the Cincinnati Medical History Society, which presented rare books to the Home.

The insurance coverage has been reviewed in detail. Various expenditures have been authorized, which include repairs to the Home, insurance, supplies, publicity, gas and electricity, miscellaneous services, payroll taxes and sales taxes, sewer tax, water, and finally, capital outlay for color postcards, pamphlets, etc., for sale to the public. The salary of the custodian, Miss Crawford, was increased to $125 per month, and of her assistant for four summer months to a similar amount. The Home may be visited on week days from 9:30 a.m. until 5:00 p.m., and on Sunday from 2:00 p.m. to 5:00 p.m. Attendance has been increasing steadily. The Medical Auxiliary has contributed greatly to the standards and success of the project, has many active committees, and has obtained funds to purchase a spinet piano of the period. The five original letters of McDowell in the Home will be reproduced by the local publisher, Mr. Enos Swain, and sold at a profit for the Home.

Constant efforts are being made to obtain authentic possessions of Ephraim McDowell, and various articles are being offered to the Home. These must be researched and certified. Ten thousand pamphlets describing the McDowell Home are being placed in the State Parks and Public Relations Department of the State government, at a cost of $90.

The financial statement of the McDowell Fund will be available after this report is written. The income will approximate $8,000. Of this amount, $4,000 was contributed by the Kentucky Medical Association and approximately $1,300 was realized from admissions, sale of cards, pamphlets, etc. In a separate category were $722.77 which represented especial contributions obtained by the Women's Auxiliary for the spinet piano, $1,000 from the Fifth District of the American College of Obstetricians and Gynecologists, $50.00 from Eduard Eichner, M.D., of Cleveland, Ohio, and $250.00 from the Southeastern Surgical Congress. It is expected that $1,000 will be donated by the Kentucky Surgical Society and $200 from the Southern Surgical Association. The latter total of $2,500 has been obtained by solicitation and at any time may not be renewed.

It is the policy of the Committee to use KMA funds only for absolutely necessary basic expense in the upkeep of the Home. Any additions or new improvements are to be paid from special solicitations.

As far as can be determined at the time this report is written, $500-$600 may be left in the account at the end of this year. At last year's end the account was over $1,000 in arrears due to necessary major repairs to the Home. Repairs of $1,000 to $3,000 may be expected in any year. Minimal basic expense on the Home, aside from repairs, varies from $400 to $800 each month, and approximates $6,000 per year.

Your committee believes that the present balance is not unreasonable as an Operating Fund. It is to be noted that the American College of Obstetricians and Gynecologists at its recent Executive Board meeting refused any contribution in response to a request for $3,000, and the American Medical Association through its Board of Trustees has not allowed any contribution to the McDowell Fund in response to a detailed request from Robert Long, M.D.

Your committee requests approval of the following:

1. That the McDowell Home be associated with an organization of Historic Homes of Kentucky at a nominal sum, to aid the public in information relating to the Home.
2. That a commemorative ceremony be held in the early fall when the McDowell Home will be designated a Registered Historic Landmark by the U.S. Department of the Interior with presentation of a certificate and plaque.
3. That the City authorities and Urban Renewal Agency of Danville, Kentucky be commended in their efforts to develope an Isaac Shelby Park between the McDowell Home and Constitution Square and redevelope the surrounding area.

The committee wishes to express its appreciation to the House of Delegates which last year increased the annual appropriation from the Association to the McDowell Home Committee from $3,000 to $4,000.

MCDOWELL HOME COMMITTEE

Laman A. Gray, M.D., Louisville, Chairman
Robert C. Bateman, M.D., Danville
Rankin C. Blount, M.D., Lexington
Mr. Sterling Coke, Lexington
Dr. Norman H. Franke, Lexington
Mr. George Grider, Danville
E. M. Howard, M.D., Harlan
Harold Priddle, M.D., Paducah
Richard H. Segnitz, M.D., Lexington
B. B. Baughman, M.D., Frankfort

Recommendations, Reference Committee No. 7

This report was studied in detail and the Committee made note of the recommendations that were made with approval requested:

1. That the McDowell Home be associated with an organization of Historic Homes of Kentucky at

a nominal sum, to aid the public in information relating to the Home.

2. That a commemorative ceremony be held in the early fall when the McDowell Home will be designated a Registered Historic Landmark by the U. S. Department of the Interior with presentation of a certificate and plaque.

3. That the City authorities and Urban Renewal Agency of Danville, Kentucky be commended in their efforts to develope an Isaac Shelby Park between the McDowell Home and Constitution Square and re-develope the surrounding area.

The Committee also feels that the House of Delegates should extend to the Fifth District of the American College of Obstetrics and Gynecologists our most sincere appreciation for their generous gift of $1,000 to the McDowell Fund. And, that we should also express our continuing thanks to the Southeastern Surgical Congress, Kentucky Surgical Society, and the Southern Surgical Association.

This report was approved by the Board of Trustees on August 5.

Mr. Speaker, I move the adoption and implementation of this section of the report. (The motion was seconded and carried.)

Report of the Memorials Commission

It was reported at the meeting of your KMA Memorials Commission that the members of the Board of Trustees had contributed twenty-five chairs to the Board Room of the Headquarters Building. Appropriate plaques bearing the names of the donors have been made and affixed on these chairs. Plans have been made to contact other members and former members of the Board in order that they may have an opportunity to participate.

It was also reported to the Commission that a beautiful clock had been contributed by one of the members of the Board and that a flagpole had been erected as a gift to the building.

The Commission was told that there was now $1100.00 in the Library-Museum Fund which the Commission expects to use in building up the library museum which is a part of the President's Office in the Headquarters Office Building. These funds come from contributions of past presidents. Other contributions in the way of books from officers and members of the Board were also received. The Commission gave full consideration to further promoting the aims of the library museum and instructed staff in the matter of implementing these plans.

MEMORIALS COMMISSION
Carlisle Morse, M.D., Louisville, Chairman
Eugene H. Conner, M.D., Louisville
G. Y. Graves, M.D., Bowling Green
J. Duffy Hancock, M.D., Louisville
Francis Massie, M.D., Lexington

Recommendations, Reference Committee No. 7

It was pleasing to note that the Board Room of the Headquarters building is being quite adequately furnished by memorial gifts and that the Library Museum Fund is increasing nicely in volume. The Committee noted that there were no problems involved with this Commission and that the report was approved by the Board.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the KMA Representative to the Conference of the Presidents and other Officers of State Medical Associations

The Twenty-First Annual Meeting of the Conference was held June 20, 1965 in the Americana Hotel, New York City. Conference President Raymond McKeown, M.D., Coos Bay, Oregon, called the session to order at 1:15 p.m., and a short business meeting followed.

A very fine address entitled "Education—The Storm Center" was made by Max Rafferty, Ed.D., of Sacramento, California. "The Changing Form of Government," title of a speech given by Justice Millard F. Caldwell of Tallahassee, Florida was a most stimulating presentation.

The meeting closed with the installation of the new president, Walter C. Bormemeier, M.D., and an informative address by Doctor Bormemeier.

Delmas M. Clardy, M. D., President
Kentucky Medical Association

Recommendations, Reference Committee No. 7

President Clardy attended this twenty-first annual meeting June 20, 1965. He reported this meeting as quite beneficial.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the KMA Representative, U of K Chapter, Student AMA

This past year has been a good one for the University of Kentucky SAMA with consolidation of their purposes and administration.

I have been able to implement invitations offered by the state and local medical societies, highlighting what might be gained by attendance at these various meetings.

Through my various contacts with the group we were able to more smoothly bring about certain functions of our Senior Day Program which was a fine success.

The year was topped off by a dance and lampoon sponsored by SAMA, which promises to be the highlight of the medical school year each year.

I have enjoyed my contact with SAMA and am pleased to be of some little service.

Richard H. Segnitz, M.D., KMA
Representative to U of K Chapter

Report of the KMA Representative, U of L Chapter, Student AMA

Another progressive and active year has been the business activities of this chapter. The usual monthly meetings and organizational functions have been well done.

The southern SAMA region met in Louisville with this chapter acting as host.

Our chapters again attended the annual national SAMA in Chicago and it is with pride and pleasure to report that a member of our chapter was elected President at this meeting. His name is James Moss. He is a native of Williamsburg, Kentucky. Both his father and grandfather have been practicing physicians. The Presidency thus rests on very substantial shoulders and with the help and support of the students and faculty at the University of Louisville, along with doctors of the State, there is no doubt in anyone's mind that he and SAMA will have an exceptionally good year.

It is felt appropriate to comment at this time, because of past questions as to who may be influencing SAMA policies, who in SAMA have assumed primary roles of leadership, or established themselves into positions of directing programs that might reflect against the best interests of medical education and would cause the practice of medicine to suffer. This has been discussed both with advisors to the SAMA from the American Medical Association and has been taken up with many members of the SAMA, both here and at other chapters. After a thorough perusal, it is the opinion of this representative from KMA that there is no substantial evidence of evil

having occurred of any appreciable degree and there does not seem to be any growing influence of this type of non-representative people. Needless to say, because of the importance of SAMA, alertness is necessary because there are those who would try to achieve dominant leadership roles in order to thwart the organization's acknowledged beneficial purposes and misdirect them into undesirable political channels. At this time, such action on the part of medical organizational enemies does not seem to have had appreciable success.

Today, SAMA is quite healthy. This is exemplified by the actions of the delegates and the selection of our most distinguished new President of SAMA.

Again, it has been a genuine pleasure and a stimulating experience to have served in the capacity of representative to our University of Louisville chapter. These young men are again expressing by word and deed, evidence of the continuing health and vigor that medicine will receive by the high caliber of people coming into our ranks from the Medical School. It is rejuvenating and encouraging to know that our profession is being enhanced and nurtured uninterruptedly because of the excellent quality of our medical youth.

Hoyt D. Gardner, M.D., KMA
Representative to U of L Chapter

Recommendations, Reference Committee No. 7

Reference Committee No. 7 feels that our Student American Medical Association groups are to be commended on the outstanding work that they are doing and that letters of appreciation should be sent to both Chapters in Kentucky. Particular note should be made in the way of commendation to the Louisville Chapter since one of their members, James Moss, has recently been elected President of the National Student American Medical Association. We appreciate their interest and continued efforts and hope that they will be made fully aware of our orientation program as recently adopted by our State Association.

Mr. Speaker, I move the adoption and implementation of this section of the report. (The motion was seconded and carried.)

As Chairman, I would like to express my appreciation to the members of this Committee: Doctors Heavern, Lowry, Evans, and Salisbury, for their diligent and dedicated work on this Committee.

Mr. Speaker, I mov ethe adoption and implementation of this report as a whole. (Motion seconded; carried.)

REFERENCE COMMITTEE NO. 7
Sam Weakley, M.D., Louisville, Chairman
Tom Heavern, M.D., Ft. Thomas
C. C. Lowry, M.D., Murray
M. J. Evans, M.D., Middlesboro
Robert J. Salisbury, M.D., Mt. Sterling

Unfinished Business

Doctor Sweeney recognized Donald Chatham, M.D., Vice Chairman for the final report of the Board of Trustees. The report follows:

Mr. Speaker, I move the adoption and implementa-
members of the 1964 KMA House of Delegates will recall that as a special action, the House voted to create the KMA Judicial Council. In taking this action, the House of Delegates created a new Chapter in the KMA Bylaws, which was designated as Chapter VII. "Discipline—the Judicial Council", and is found on page 7 of the printed copy in your House of Delegates envelope.

In checking Chapter VII of our Bylaws, you will observe that there are five members on the Council, one of the members shall be the KMA Secretary, and there shall be four members elected, and the terms staggered so that there will be one elected each year. It is provided that there will be a representative from each of the three traditional districts, central, western and eastern, and a member at large. The Bylaws state:

"To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or as Delegate to the AMA, or (2) Have served five years as a member of this House of Delegates."

Mr. Speaker, the Bylaws further provide that the Board of Trustees shall make nominations for each of the four positions, and that members of the House of Delegates may make nominations from the floor for any of these positions.

Those of you who were here last year will recall that as soon as Chapter VII, calling for the setting up of the Judicial Council, was passed, that the problem of getting the Council underway at that time was discussed. It was decided by the House, in a special action, to have the Board of Trustees elect members of the Judicial Council to serve for one year only, and that at this 1965 meeting, the Board would make recommendations for the staggered terms for consideration by this House.

At the regular reorganization meeting of the Board last year, it did elect four people to serve temporarily. At the August 4 meeting of the Board this year, it voted to make the following nominations to the House of Delegates in such a way as to comply with the terms of the Bylaws, both from the standpoint of qualifications, and staggering the terms. They are:

N. L. Bosworth, M.D., Lexington, Eastern District, for a four-year term.
Duffy Hancock, M.D., Louisville, Central District, for a three-year term.
Clyde C. Sparks, M.D., Member at Large, for a two-year term.
Hugh L. Houston, M.D., Murray, Western District, for a one-year term.

Doctor Chatham moved the adoption of the report. The motion was seconded and carried.

Election of Officers

The Speaker called for the report of the Nominating Committee, which was presented by its chairman, Harold B. Barton, M.D., Corbin. Doctor Barton read the following list of nominations for the positions to be filled as follows:

President-Elect	Robert E. Pennington, M.D., London
Vice-Presidents	
Central	George W. Pedigo, M.D., Louisville
Eastern	Donald K. Dudderar, M.D., Newport
Western	C. C. Lowry, M.D., Murray
Speaker of House	George F. Brockman, M.D., Greenville
Vice-Speaker of House	Richard F. Greathouse, M.D., Louisville
AMA Delegate	Charles C. Rutledge, M.D., Hazard
AMA Alternate Delegate	David B. Stevens, M.D., Lexington
AMA Delegate	John C. Quertermous, M.D., Murray
AMA Alternate Delegate	William W. Hall, M.D., Owensboro

After each nomination was presented, the Speaker called for nominations from the floor. No nominations were received and it was moved and seconded that the nominees be elected. Motion carried.

The following nominations for the offices of trustees were submitted by Doctor Barton:

First District	Joseph R. Miller, M.D., Benton
Third District	Gabe A. Payne, Jr., M.D., Hopkinsville
Fourth District	Henry S. Spalding, M.D., Bardstown
Twelfth District	Robert F. Long, M.D., Somerset
Fourteenth District	James W. Archer, M.D., Paintsville

The same procedure followed in electing the general officers was followed in the election of the trustees. Since there were no nominations from the floor, the above-named nominees were elected.

Doctor Pennington, the new president-elect, was escorted to the rostrum. He received a standing ovation.

Nominations for Board of Directors, Kentucky Physicians Mutual, Inc.

The following list of nominees for the Board of Directors, Kentucky Physicians Mutual, Inc., was submitted and received for information only:

Everett H. Baker, M.D., Louisville
Mr. Leonard Campbell, Ashland
William H. Cartmell, M.D., Maysville
Delmas M. Clardy, M.D., Hopkinsville
Hubert C. Jones, M.D., Berea
Ralph D. Lynn, M.D., Elkton
Oscar O. Miller, M.D., Louisville
J. Vernon Pace, M.D., Paducah
Mr. Lewis Rodenberg, Frankfort
John T. Walsh, M.D., LaGrange
John C. Quertermous, M.D., Murray
William W. Hall, M.D., Owensboro
Roy H. Moore, M.D., Louisville
Charles C. Rutledge, M.D., Hazard

Election of 1964 Nominating Committee

The nominating committee to serve at the 1966 Annual Meeting was elected as follows:

Harold B. Barton, M.D., Corbin
Ballard M. Cassady, M.D., Pikeville
Irving F. Kanner, M.D., Lexington
W. Vinson Pierce, M.D., Covington
William T. Rumage, Jr., M.D., Louisville

Everett H. Baker, M.D., Louisville, was installed as president. The oath of office was administered by the chairman of the Board of Trustees, Robert E. Pennington, M.D. President Baker presented the Past President's Plaque to the retiring president, Doctor Clardy.

Doctor Baker made brief remarks to the members of the House. Doctor Sweeney thanked the members of the House of Delegates for their cooperation during both sessions. The second session of the 1965 House of Delegates was adjourned at 12:00 p.m.

April 13-14

KMA Interim Meeting

DuPont Lodge

Cumberland Falls

ORGANIZATION SECTION

KMA Interim Meeting to be Held Apr. 13-14 at Cumberland Falls

Plans for the 1966 KMA Interim Meeting, to be held at Cumberland Falls April 13-14, are nearing completion, Everett H. Baker, M.D., Louisville, KMA president and chairman of the Interim Meeting Program Committee, has reported.



Doctor Appel

Following the meeting of the Program Committee in Harrodsburg November 3, Doctor Baker announced that several guest speakers of national prominence have been invited to participate in the meeting.

James Z. Appel, M.D., Lancaster, Pa., president of the American Medical Association, has accepted an invitation to speak at the luncheon meeting.

Important topics to be covered at the meeting include labor's viewpoints on pre-payment plans; the operation of PL 89-97 (medical care for the aged) by the Social Security department; and development of the Appalachian Regional program with special emphasis on health.

Doctor Baker said that further information on the program of the Interim Meeting will be published in later issues of The Journal. The meeting will be held at DuPont Lodge at Cumberland Falls. It is suggested that reservations be made early.

Dr. Morse, Former KMA Officer, Dies Suddenly in Louisville

Carlisle Morse, M.D., Louisville, past chairman of the KMA Council (now Board of Trustees), and a former vice-president of the Association, died suddenly October 30 at a Louisville Hospital He was 71.

Chairman of the KMA Memorials Commission at the time of his death, Doctor Morse was a former chairman of the Diabetes Committee and had served in numerous other KMA council and committee posts.



Doctor Morse

He was assistant clinical professor of medicine at the University of Louisville School of Medicine, which awarded him his medical degree in 1930. He was a fellow in the American College of Physicians and a member of the Southern Medical Association, the American Society of Internal Medicine, and a member of the Board of the American Diabetes Association.

Doctor Morse was a former secretary and treasurer of the Jefferson County Medical Society, and a past president of the St. Matthews Rotary Club. He was an elder and former chairman of the Board of the Beargrass Christian Church.

KMA First, Second, and Eighth Trustee Districts to Meet

As we go to press three KMA trustee districts have scheduled district meetings. You are urged to watch for your invitation from your trustee, which will reach you several weeks before your meeting, and which will contain full details.

W. Gerald Edds, M.D., Calhoun, trustee for the Second District, has called a meeting of his members for Tuesday evening, January 11, at Gabe's Restaurant in Owensboro.

The First District, according to Joseph R. Miller, M.D., Benton, will have a dinner meeting at the Paducah Country Club on Wednesday evening, January 26.

The third meeting has been scheduled by W. Donald Janney, M.D., trustee of the Eighth District, for April 7, to be held in Covington.

KMA District Key Men to Meet Jan. 12 at Louisville

A program covering the functions of the Key Man system, outlining responsibilities and procedures, will be held for all KMA district key men January 12 at the Brown Suburban Hotel in Louisville.

The two chairmen of the Council on Legislative Activities, John C. Quertermous, M.D., Murray, (National Affairs), and James C. Cantrill, M.D., Georgetown, (State Affairs) will preside and be responsible for the program.

At press time plans were being made for inviting an out-of-state speaker for the luncheon during the day-long session.

All key men will be informed of their appointments early in December, and are urged by KMA President Everett H. Baker, M.D., and the legislative chairmen to attend this important meeting.

KMA and School Representatives To Discuss Medical Education

Representatives of Kentucky's two medical schools and the Kentucky Medical Association will hold a retreat at Park Mammoth Resort near Park City on January 22 and 23 to discuss the problems and long-range objectives of medical education in the state.

The conference, proposed at the September 19 meeting of the KMA Board of Trustees, will be composed of 15 representatives each from the University of Louisville and the University of Kentucky medical schools, and 30 from KMA.

An agenda committee made up of two persons from each school and three KMA members, was scheduled at press time to meet December 8 at the KMA Headquarters office to plan the program for the meeting.

Dr. Farabee Appointed New Head Of Mental Health Department

Dale Henry Farabee, M.D., chief of the psychiatry section at the University of Kentucky Health Service, has been appointed by Governor Edward T. Breathitt as new Commissioner of Mental Health for Kentucky. The appointment became effective November 1.



Doctor Farabee

Doctor Farabee, a 1958 graduate of the University of Louisville School of Medicine, replaces Harold McPheeters, M.D., who resigned in September, 1964 to accept a position in New York. Doctor Farabee accepted the post at a salary of $25,000 per year. The former commissioner received $17,000.

The new mental health chief received his bachelor's degree from Indiana University in 1951. After completing a residency in psychiatry, he was director of the Eastern region of the Department of Mental Health's division of community services.

Methodist Hospital Postgraduate Program Scheduled for Jan. 19

The first Postgraduate Education Day of Methodist Evangelical Hospital in Louisville will be presented by the hospital medical staff on January 19, according to Orson P. Smith, M.D., chairman of the Postgraduate Education Committee.

"Modern Concepts of Renal Disease" will be the theme of the program, which is designed to appeal to a wide section of the medical profession.

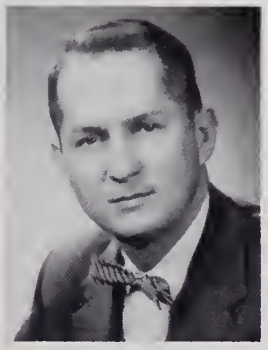
Principal speakers will be Edward Kass, M.D., director of the Channing Laboratory at Boston City Hospital; H. V. Murdaugh, M.D., director of the renal division, department of medicine, University of Pittsburgh; and Leonard Berman, M.D., director of the renal section, department of medicine, University of Louisville.

The program, which will last from 8:30 a.m. to 4:30 p.m., will see six half-hour presentations in the morning, and five in the afternoon, each followed by a question and answer session.

All physicians are cordially invited to attend the Postgraduate Education Day. The program has been submitted to the Kentucky Academy of General Practice for approval.

Dr. Witten Appointed by LBJ To Medicare Advisory Post

Carroll L. Witten, M.D., Louisville, president-elect of the American Academy of General Practice, was appointed November 11 as one of nine physicians on the Federal Advisory Committee for the implementation of the medicare program. (Public Law 89-97).



Doctor Witten

The 16-member Health Insurance Benefits Advisory Council met for the first time November 12 and 13 in Washington. Its goal is to help form policies for the administration of the program under PL 89-97.

Doctor Witten, who attended the Washington meeting, is currently president of the Kentucky Acadmey of General Practice. He is a member of the U.S. Surgeon General's Committee on Indian Health, and serves as a consultant to the Public Health Service's Division of Indian Health.

KAGP Plans Northern Ky. Seminar

The Kentucky Academy of General Practice is completing plans for its annual Northern Kentucky Seminar, to be held January 21 at South Fort Mitchell, according to L. C. Hess, M.D., Florence, program chairman.

Doctor Hess said that the theme of the morning session will be vascular disease. At press time, plans for the afternoon program were still incomplete. The seminar, to be held at the Holiday Inn Cincinnati South, will last all day, beginning at 9:30 a.m.

AN ADDITION

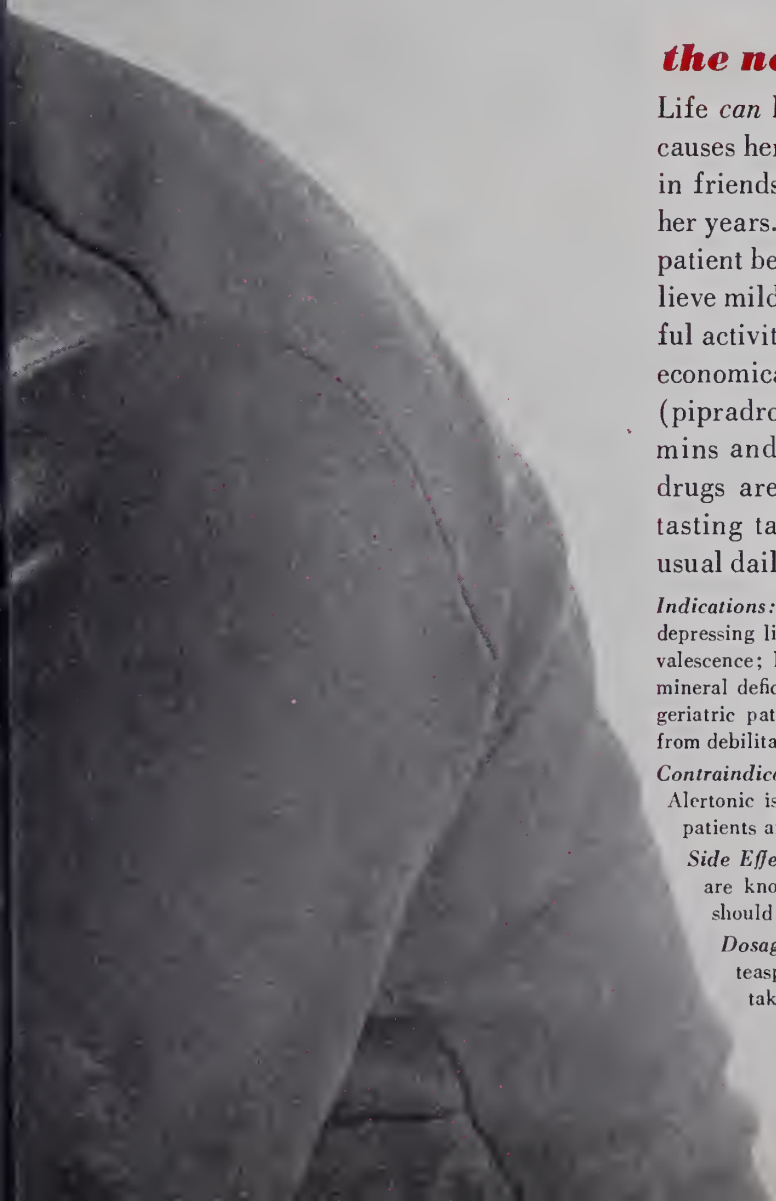
In listing the names of those absent from the picture of the Board of Trustees in the November issue, The Journal inadvertantly ommitted those of George P. Archer, M.D., Keith P. Smith, M.D., Douglas E. Scott, M.D., and John C. Quertermous, M.D. The Journal apologizes to these gentlemen for the omission.


too young
to be so tired...

revive interest...restore activity promptly with Alertonic®

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline†, 100 mg.; inositol†, 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.



the need for a tonic knows no age

Life *can* begin at forty—except when functional fatigue causes her to feel tired all the time; to start losing interest in friends and surroundings; to look and act older than her years. Alertonic—*a prescription tonic*—can help your patient become her normal self again. Alertonic helps relieve mild depression, revive interest and restore purposeful activity promptly...with a formula that is efficient *and* economical. Alertonic contains a mild central stimulant (pipradrol hydrochloride), 15% alcohol, essential vitamins and minerals. No hormones or MAO-inhibiting drugs are included. No iron. No iodine. One pleasant-tasting tablespoonful before each meal comprises the usual daily dose.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

Side Effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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Advisory Unit Discusses Draft With Selective Service Head

The KMA Advisory Committee to Selective Service recently met with Col. Everette S. Stephenson, director of Selective Service for the State, and his staff, to discuss the needs of the current physicians' draft call.

About 160 physicians from Kentucky, 35 years old and under, have been ordered to report for pre-induction physical examinations. Some of this number will be drafted in January. The purpose of the Committee is to help maintain a balance between the number of physicians required to meet the health care needs of the state and those required for the draft.

J. Duffy Hancock, M.D., Louisville, chairman of the KMA Committee, stated that all requests for information on any special situation should be directed to Colonel Stephenson at 220 Steele St., Frankfort. Ky.

Other physician members of the Committee are Glenn U. Dorroh, M.D., Lexington, vice-chairman; James Archer, M.D., Paintsville; Charles B. Billington, M.D., Paducah; Sydney G. Dyer, M.D., LaCenter; Sam A. Overstreet, M.D., Louisville; Russell E. Teague, M.D., Frankfort; and L. O. Toomey, M.D., Bowling Green.



Mrs. Everett D. Blair, Morehead, right, chairman of Rural Health for the KMA Woman's Auxiliary, sorts articles of clothing presented by the Auxiliary to the Frontier Nursing Service at Hyden, during the annual Fall Conference and Board Meeting of the Auxiliary. (See accompanying story.) With Mrs. Blair are, from left, Mrs. Charles W. Allen, Jr., corresponding secretary of the Nursing Service; John W. Greene, Jr., M.D., Lexington, and Miss Kate Ireland, member of the executive committee of the Nursing Service's Board of Trustees.

WA-KMA Holds Fall Conference, Board Meeting Nov. 9

State officers, County presidents and presidents-elect of the Woman's Auxiliary to KMA met November 9 for their annual Fall Conference and Board of Director's meeting at the KMA Headquarters office in Louisville.

Mrs. Robert J. Salisbury, Mt. Sterling, Auxiliary president, presided at the meeting. John W. Greene, Jr., M.D., Lexington, chairman of the department of obstetrics and gynecology at the University of Kentucky Medical Center, addressed the group at its morning session. During the afternoon business meeting, reports of officers and state chairmen were given.

In accordance with the Auxiliary's emphasis this year on state health projects, Miss Kate Ireland and Mrs. Charles W. Allen, Jr., representing the Frontier Nursing Service, Hyden, accepted clothing, bandages, and other necessities donated to the Nursing Service by the Auxiliary. Assistance to the Nursing Service is to be a major auxiliary project this year.

Dr. Barnes Honored at Meeting As Pathologist of the Year

Malcolm L. Barnes, M.D., Louisville, was named "private practitioner of pathology of the year" in the United States at a meeting of the Private Practitioners in Pathology Foundation in Chicago in October.



Dr. Barnes

Doctor Barnes, a past president of the Foundation, was given a plaque recognizing his outstanding contributions to the profession. In 1963 he was named "American Clinical Scientist of the Year" by the Association of Clinical Scientists.

He is an associate professor of pathology at the University of Louisville and adjunct professor of pathology at the University of Kentucky. Doctor Barnes has been active in forensic medicine in KMA, and has sought to improve on the coroner system in Kentucky.

Dr. Dye Speaks at JH Seminar

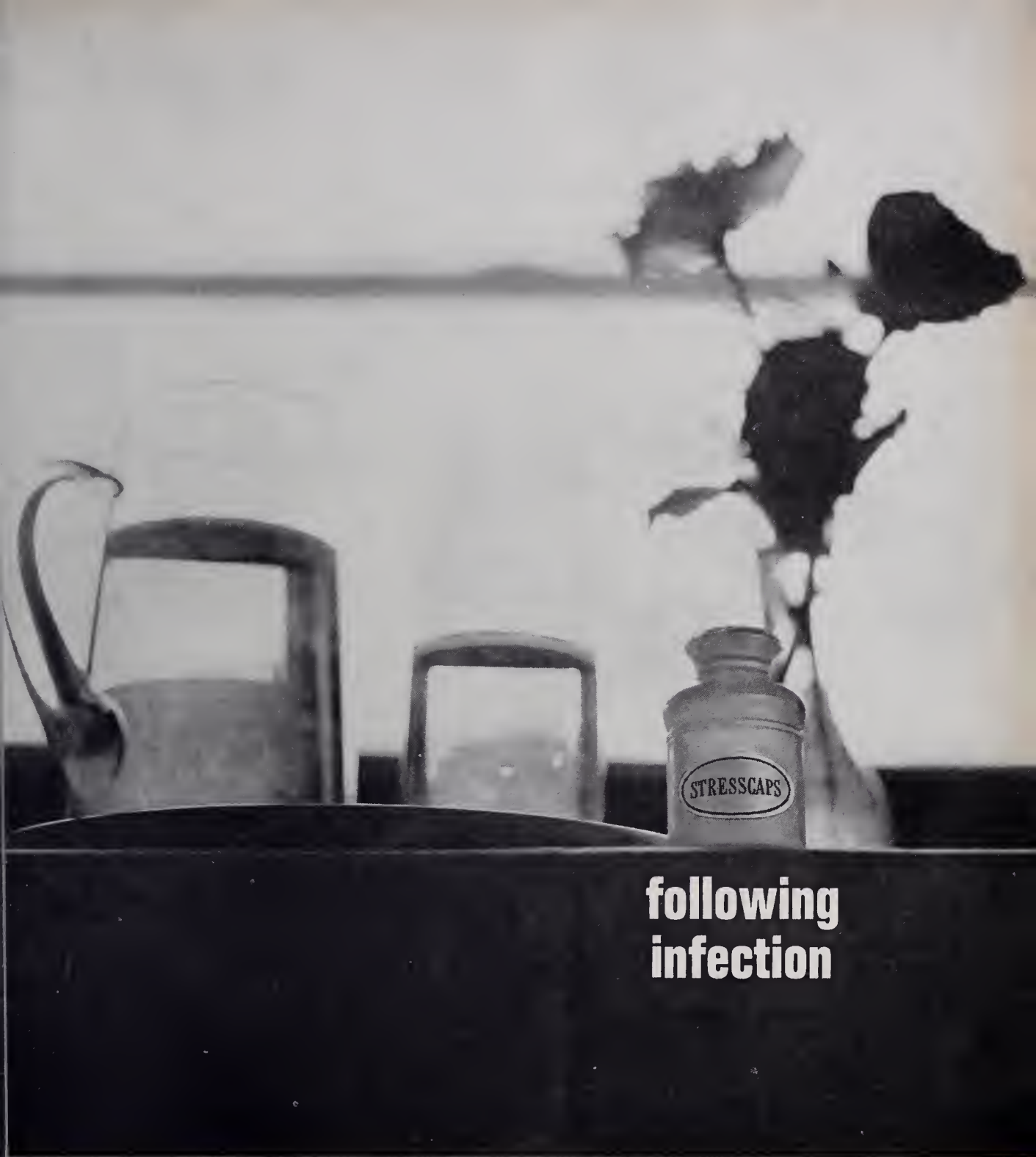
William S. Dye, M.D., clinical professor of surgery at the University of Illinois, Chicago, was the principal speaker at the Annual Jewish Hospital Seminar on Cardiovascular Diseases held December 2 in Louisville.

Other speakers on the program of the seminar included local authorities Leonard Leight, M.D., Kareem Minhas, M.D., Morris M. Weiss, M.D., and Allan Lansing, M.D. George Y. Shpilberg, M.D., Louisville, served as chairman of the program committee.

Ky. Gets Health Facility Grants

The U.S. Department of Health, Education and Welfare has approved grants amounting to $1,985,500 for hospital and public health center construction in five Kentucky areas, according to published reports.

The grants, which are to be matched locally on a 50-50 basis, will be given to Henderson, Cynthiana, Madison County, Bullitt County, and Trimble County.



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KMA Announces Enrollment of 13 New Members as of Nov.

The membership department of the Kentucky Medical Association has announced the enrollment of 13 new members as of November 18. All are from Louisville and Lexington.

Listed from Lexington are the following: Louis D. Dubilier, M.D., Jan D. Hasbrouck, M.D., Bernard O. Rand, M.D., and David W. Scott, M.D.

Louisvillians now registered as members are: Jose Amorocho, M.D., R. L. Beanblossom, M.D., (Valley Station), Vernon Bundy, M.D., Charles E. Dobbs, M.D., Stuart A. Fink, M.D., Patrick Galla, M.D., Ahmad Hatam, M.D., Donald Kmetz, M.D., and Menefee Seay, M.D.

Senior Day Programs Scheduled

The KMA Senior Day Committee, at its November 12 meeting, outlined Senior Day programs for the University of Louisville and the University of Kentucky Senior Medical Students. It was decided that the twelfth annual U. of L. program would be presented in Louisville March 21 and the third annual U. of K. program in Lexington April 12.

These annual affairs are sponsored by KMA in cooperation with the Jefferson County and Fayette County Medical Societies. Each features outstanding guest speakers at the program's closing dinner, in addition to presentations by numerous KMA members throughout the day. It was agreed that the format used in previous years would be followed again in 1966.

Physicians Mutual Board Elects

Richard J. Rust, M.D., was re-elected president of the Board of Directors of Kentucky Physicians Mutual, Inc., at the annual meeting of the Board in Louisville November 4. R. W. Robertson, M.D., Paducah, was re-elected first vice-president.

Other officers named to additional terms were Garnett J. Sweeney, M.D., Liberty, second vice-president; Branham B. Baughman, M.D., Frankfort, Treasurer; Stanley T. Simmons, M.D., Louisville, Medical consultant; D. Lane Tynes, Louisville, executive director; and J. P. Sanford, Louisville, secretary and assistant treasurer.

Dr. Maddox, Campton, is Subject Of Look Magazine Article

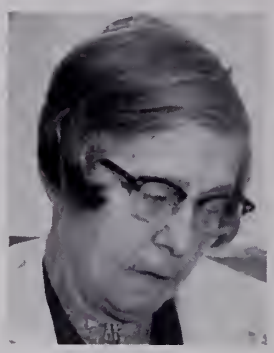
Paul F. Maddox, M.D., Campton, was the subject of a five-page spread in an early-November issue of *Look* Magazine.

The KMA's clipping service processed numerous comments from Eastern Kentucky newspapers on the national magazine's write-up.

The Cincinnati Post and Times Star, commented editorially, stating, "His reward isn't money. It is the satisfaction of service to his people and the continued effort to improve their health and welfare."

Former U. of L. Instructor Dies

Katherine Dodd, M.D., 73, a well-known pediatrician and former faculty member at the University of Louisville School of Medicine, died November 7 in Boston. At the time of her death she was a professor of pediatrics at Emory University in Atlanta.



Doctor Dodd

Doctor Dodd came to Louisville in 1957 as distinguished professor of pediatrics after official retirement as head of the pediatrics department at the University of Arkansas. She taught at U. of L. for three years. Since leaving the state she had returned on two occasions as a guest speaker at the KMA Annual Meeting. Doctor Dodd was a graduate of Johns Hopkins University School of Medicine.

Dr. Pellegrino Named to Office

Edmund D. Pellegrino, M.D., chairman of the department of medicine at the University of Kentucky College of Medicine, was elected president of the Kentucky Chapter, American College of Chest Physicians at its September 21 meeting in Louisville. Nathan Levene, M.D., Louisville, was elected vice-president, and Alex Saliba, M.D., Louisville, was named as secretary and treasurer.

Dermatology Group Elects

Winston U. Rutledge, M.D., Louisville, was elected president of the Kentucky Dermatological Society on September 23, succeeding A. B. Loveman, M.D., also of Louisville. The elections took place at the meeting of the Society held in Louisville during the KMA Annual Meeting.

Carey C. Barrett, M.D., Lexington, was named president-elect of the organization, and William E. McDaniel, M.D., Lexington, was elected secretary.

First Welch Memorial Award Presented by Blue Shield

The first annual Norman A. Welch, M.D., Memorial Award was presented October 25 during the annual Program Conference of the National Association of Blue Shield Plans in Chicago to Herbert E. Klarman, Ph.D., a professor at Johns Hopkins.

The award was established by NABSP in memory of the late AMA president, who was active in Blue Shield at local and national levels for many years.

The award is a medallion of solid gold embossed with a bust of Doctor Welch. In addition, $1,000 was contributed in Doctor Klarman's name to the Norman A. Welch, M.D., Memorial Fund of the AMA's Education and Research Foundation. Doctor Klarman won the award for his book, *Economics of Health.*



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AMA Judicial Council to Sponsor Medical Ethics Essay Contest

The American Medical Association, through its Judicial Council, will sponsor a Medical Ethics essay contest, to be known as the Norman A. Welch, M.D., Essay Contest, open this academic year to junior and senior medical students in accredited U.S. Medical schools.



Doctor Welch

The contest is named in honor of the late Doctor Welch, who died last year while serving as 118th president of the AMA. First prize in the contest will be $500, second prize $300, and third prize, $200. The deadline for entries is June 1, 1966.

Complete contest rules, as well as suggested essay topics, are available upon request from the Department of Medical Ethics, American Medical Association, 535 North Dearborn St., Chicago, Ill., 60610. They may also be obtained from the offices of the medical school deans.

Pediatricians Elect Dr. McLeod

Robert N. McLeod, M.D., Somerset, will serve as chairman of the Kentucky Chapter of the American Academy of Pediatrics for the coming year, it has been announced. Other officers named were: Richard F. Greathouse, M.D., Louisville, vice-chairman, and Noble T. Macfarlane, M.D., Lexington, secretary.

Psychiatrists Choose Dr. Weldon

Thomas A. Weldon, M.D., Covington, has been elected president of the Kentucky Psychiatric Association for the coming year. Other officers serving with Doctor Weldon will be Harvey St. Clair, M.D., Louisville; Ray H. Hayes, M.D., Anchorage, secretary; and Louis Foltz, M.D., Louisville, delegate from the Kentucky Society to the American Psychiatric Association.

Nine Ky. M.D.s Inducted by ACS

Nine Kentucky surgeons were inducted as fellows of the American College of Surgeons on October 21 during the annual five-day ACS clinical congress in Atlantic City, N.J.

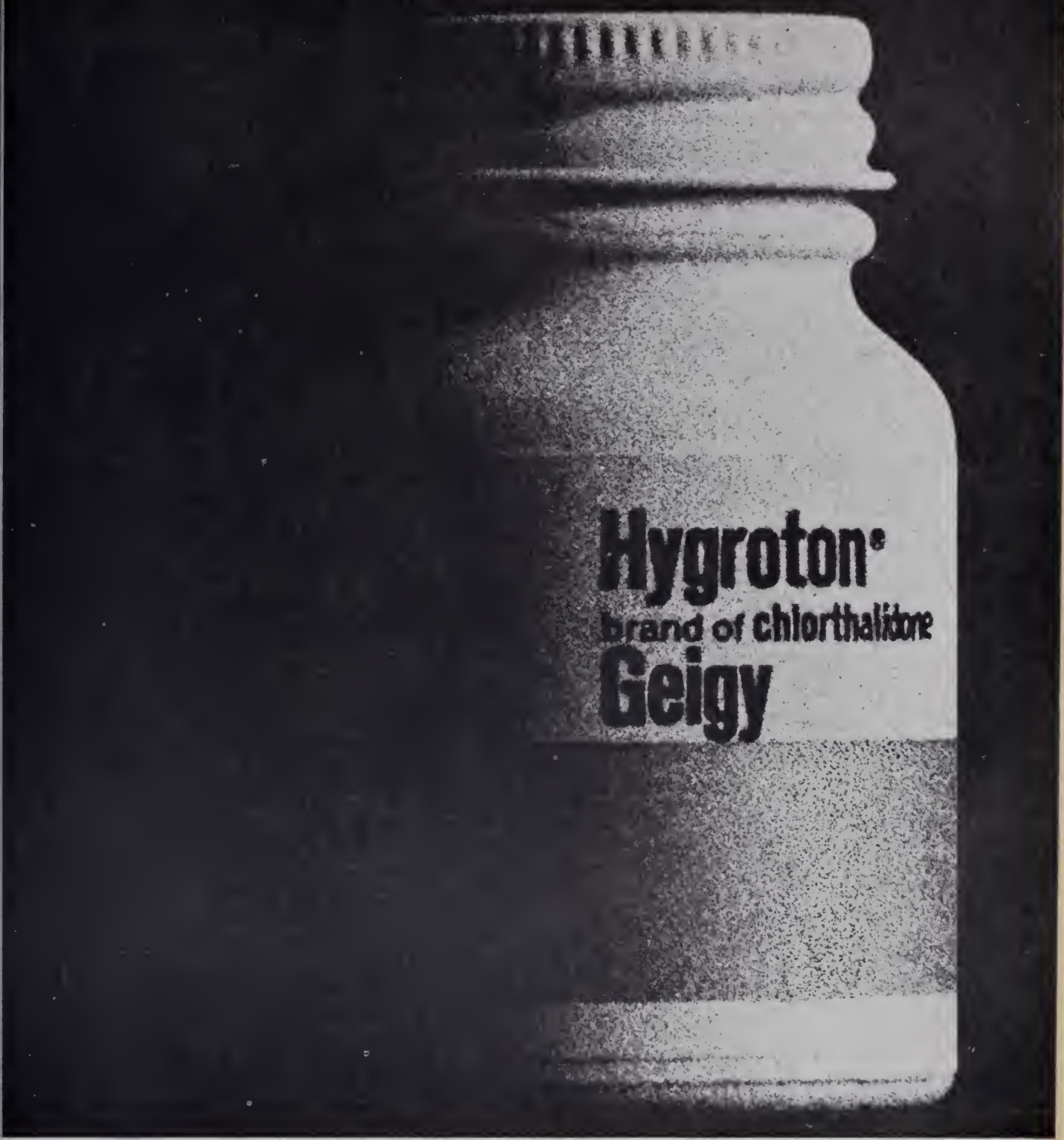
The physicians, representing several branches of surgery, are: Richard D. Floyd, M.D., Samuel O. Hodges, M.D., William G. Malette, M.D., and Charles B. Wilson, M.D., all of Lexington; Gerald D. Landau, M.D., and Allan M. Lansing, M.D., both of Louisville; George E. Ainsworth, M.D., and William R. Jernigan, M.D., Madisonville; and Robert L. Davis, M.D., Winchester.

Description: Hygroton, brand of chlorthalidone, is an oral diuretic agent of value in the treatment of edema and hypertension. The drug is notable for its prolonged action (48-72 hours) and low toxicity. It is not a thiazide and may often be employed successfully in patients who are intolerant of other agents or become refractory to them.
Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000. For full details, see the complete prescribing information.

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Edema in pregnancy...or obesity.
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And those you want to keep at dry weig
Those you want on single daily doses.
And those requiring even fewer doses
Those resistant to other therapy.
And those intolerant of other diuretics.
Those who have to pinch pennies.
And those who can afford the best.

M.D.s go to White House Meeting

Invited from Kentucky to attend the November 3-4 White House Conference on Health were Everett H. Baker, M.D., Louisville, KMA president; Russell E. Teague, M.D., Frankfort, Commissioner of Health for Kentucky; and Carroll L. Witten, M.D., Louisville, president of the Kentucky Academy of General Practice.

Doctor Baker was unable to attend because of previous commitments. The Conference covered three categories of health problems—health care, health professions' education, and health protection.

Medical Assistants Meet in N.Y.

Mrs. Wanda Taylor, president of the Kentucky State Association of Medical Assistants, Mrs. Ernestine Gates, president-elect, and Miss Dorothy Downs, immediate past president, all of Louisville, headed a delegation of nine from the KSAMA attending the ninth annual convention of the American Association in New York City October 12-17.

Among actions taken by the AAMA House of Delegates were the following: the creation of an executive committee of the Board of Trustees; establishment of the office of executive director and the assignment of duties to that office; provision that the Speaker appoint certain officers; and rejection of a dues increase. A record attendance of 833 was noted.

Dr. Stevens Heads Orthopedists

David B. Stevens, M.D., Lexington, was chosen to head the Kentucky Orthopedic Society for 1965-66, during elections held at the September 21 Society meeting held in conjunction with the KMA meeting in Louisville. Also elected at that time were Fred E. Coy, Jr., M.D., Louisville, vice-president, and Wayne Kotcamp, M.D., Louisville, re-elected secretary.

Dr. Bell Named to U. of L. Board

Jesse B. Bell, M.D., a Louisville general practitioner was appointed to the University of Louisville Board of Overseers by the University's Board of Trustees at their regular monthly meeting October 20. Doctor Bell is the first Negro to serve on the Board.

A past president of the Bluegrass Medical Society, he is a member of KMA and the Jefferson County Medical Society. Appointed last year by Governor Edward T. Breathitt to the Kentucky Commission on Higher Education, he is also a member of the Ursuline College (Louisville) advisory council. Doctor Bell graduated in 1931 from Meharry Medical College.

The Third Annual Midwest Conference on Anesthesiology will be held at the Continental Plaza Hotel, Chicago, on April 28-30. For information contact: T. L. Ashcraft, M.D., general chairman, 33 East Cedar Street, Chicago, Ill., 60611.

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Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

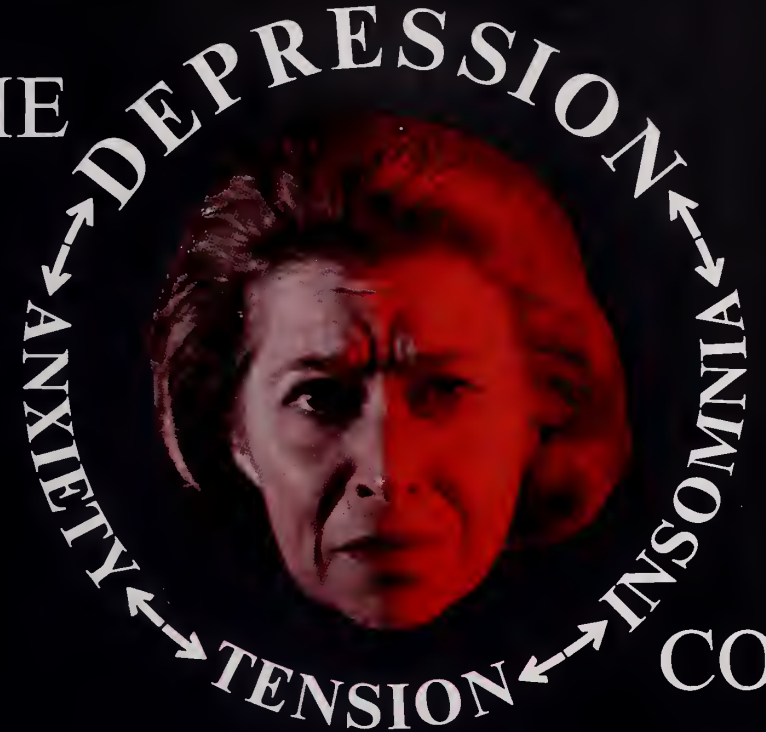
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NEWS ITEMS

O. B. Murphy, M.D., Lexington orthopedic surgeon, was awarded the Lexington Jaycees' Physical Fitness Award for overall contribution to the community at a recent Jaycee meeting. Doctor Murphy is chairman of the KMA School Health Committee and a member of a similar committee of the AMA.

C. C. Risk, D.D.S., Shelbyville, who for the past several decades has been county society secretary for the Shelby County Medical Society, passed away November 18. Doctor Risk, who retired several years ago, was 80.

Robert C. Kratz, M.D., Newport, was chairman of a conference group on "Surgical Treatment of Salivary Gland Tumor" at the International Congress of Otorhinolaryngology in Tokyo, Japan, in October.

Samuel O. Hodges, M.D., and **Eugene Q. Parr M.D.**, have announced their association in the practice of orthopedic surgery at Lexington. Doctors Hodges and Parr, both graduates of the University of Louisville School of Medicine, were formerly partners in general practice at Berea.

J. M. English, M.D., a general practitioner in Hardin county since 1904, has announced his retirement from practice, effective in October. Doctor English is a former president of the Hardin County Medical Society.

Rudolph J. Muelling, M.D., director of the division of legal medicine at the University of Kentucky, was recently elected a second vice-president of the National Association of Coroners. Doctor Muelling is also professor of pathology at the University.

Kenneth Welsh, M.D., Rowan County Health Officer, was a representative of the Public Health Service from Region III (Southeastern U.S. and Puerto Rico) at the annual meeting of the American Public Health Association in Chicago in October.

Cathryn Cornett, M.D., Liberty, has been appointed health officer for Casey, Boyle, and Lincoln counties, replacing **Ray Campbell, M.D.**, who held the office for five years before resigning to take postgraduate training at the University of Kentucky Medical Center.

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John D. Perrine, M.D., has joined the staff of the Student Health Service at the University of Kentucky Medical Center. A gastroenterologist, Doctor Perrine, who was graduated in 1960 from Vanderbilt University School of Medicine, interned at the University Medical Center, Jackson, Miss., and was a resident in internal medicine there before accepting a two-year fellowship in gastroenterology at Vanderbilt.

In Memoriam

WADE G. SHACKLETT, M.D.
(Formerly) Valley Station, Ky.
1876-1965

Wade G. Shacklett, M.D., a general practitioner in the Valley Station area for 54 years, died November 4 in Berkeley, Calif., where he had lived since 1960. Doctor Shacklett, 88, was a former director of the Bank of St. Helens and a member of Valley Masonic Lodge. He was graduated in 1906 from the Medical Department of the University of Louisville.

WILLIAM J. HOCKADAY, JR., M.D.
Louisville, Ky.
1924-1965

William J. Hockaday, Jr., M.D., Louisville psychiatrist, died suddenly at his home November 17. He was 41 and an assistant professor of psychiatry at the University of Louisville School of Medicine. A 1948 graduate of the U. of L. medical school, Doctor Hockaday received his postgraduate training at Louisville General Hospital, Norton Infirmary, Baylor University and New York Hospital, White Plains, N.Y.

WILLIAM B. FOREMAN, M.D.
Louisville, Ky.
1883-1965

William B. Foreman, M.D., 82, Louisville general practitioner, died November 17 at his home. He had practiced in Louisville for 51 years. An emeritus member of the Kentucky Medical Association, Doctor Foreman also belonged to the Jefferson County Medical Society and the AMA. He was a member of the Excelsior Masonic Lodge. He received his medical training at the Louisville Medical School, where he graduated in 1909.

JOHN W. McGOWAN, M.D.
Lexington, Ky.
1925-1965

John W. McGowan, M.D., Lexington anesthesiologist, died suddenly October 31 at his home. A native of Hopkinsville, Doctor McGowan was 40. He received his medical degree from the University of Louisville School of Medicine in 1948. Doctor McGowan was a member of the county, state, and American Medical associations.

Councils and Committees of the Councils, Standing and Miscellaneous

Committees for the 1965-66 Associational Year

Council on Scientific Assembly

Everett H. Baker, M. D., Louisville, Chairman
Robert E. Pennington, M. D., London, Vice Chairman
Harvey Chenault, M. D., Lexington
Benjamin B. Jackson, M. D., Louisville
Roderick Macdonald, Jr., M. D., Louisville
Edmund D. Pellegrino, M. D., Lexington
Willett H. Rush, M. D., Frankfort

Scientific Program Committee

Roderick Macdonald, Jr., M. D., Louisville, Chairman
Everett H. Baker, M. D., Louisville
Harvey Chenault, M. D., Lexington
Eugene H. Conner, M. D., Louisville
Edmund D. Pellegrino, M. D., Lexington
Ray J. Timmerman, M. D., Newport
J. Sankey Williams, M. D., Nicholasville

Golf Committee

James B. Douglas, M. D., Louisville, Chairman
Harold W. Baker, M. D., Louisville
Bernard J. Baute, M. D., Lebanon
Merle W. Fowler, Jr., M. D., Paducah
P. B. Hall, M. D, Paintsville
Edward G. Houchin, M. D., LaGrange
Kenton D. Leatherman, M. D., Louisville
D. Maurice Royalty, M. D., Lexington
Harvey B. Stone, M. D., Hopkinsville
Nathan Zimmerman, M. D., Louisville

Technical Exhibits Committee

Willett H. Rush, M. D., Frankfort, Chairman
Clyde M. Brassfield, M. D., Elizabethtown
Giles L. Stephens, M. D., Louisville

Awards Committee

William H. Bizot, M. D., Louisville, Chairman
Richard Grise, M. D., Bowling Green
James M. Keeton, M. D., Ashland
Joseph Keith, Jr., M. D., Lexington
Max D. Klein, M. D., Shelbyville

Scientific Exhibits Committee

Benjamin B. Jackson, M. D., Louisville, Chairman
Howard E. Dorton, M. D., Lexington
Thomas R. Marshall, M. D., Louisville

Council on Medical Education and Hospitals

George A. Sehlinger, M. D., Louisville, Chairman
James D. Holloway, M. D., Lexington
Walter I. Hume, Jr., M. D., Louisville
Andrew M. Moore, M. D., Lexington
Donn L. Smith, M. D., Louisville
William R. Willard, M. D., Lexington
William P. VonderHaar, M. D., Louisville

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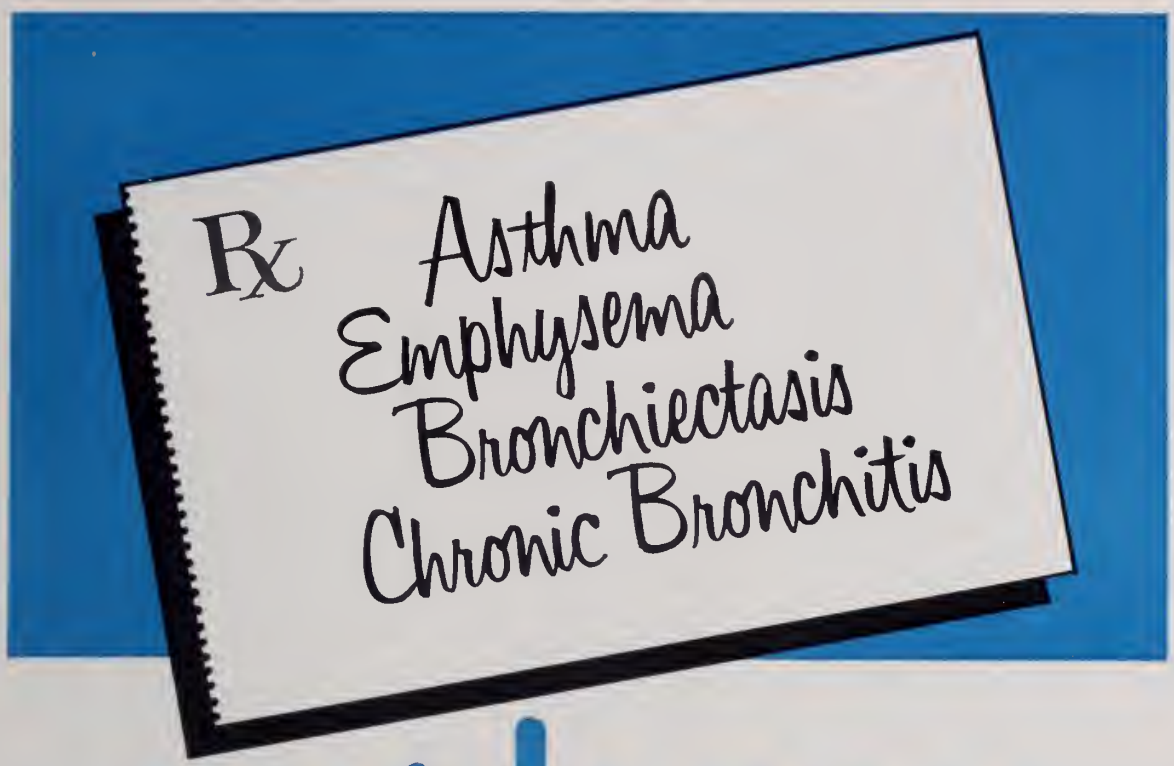
Blue Shield — 1965 Variety

(Continued from Page 964)

cine has been developing Blue Shield, has it been clearer and more imperative for us to close ranks behind Blue Shield and to give Blue Shield our utmost cooperation and encouragement.

Some of us feel that had medicine fully supported its own prepayment program over the past 25 years, there might have been no call for a King-Anderson Bill—but all this is now speculation. However, it is not too late for us to use the instruments and facilities that we have, so that the profession may play a fully effective and responsible role in the development of medical practice in the future.

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IN KENTUCKY

DECEMBER

16 Norton Memorial Infirmary Annual Postgraduate Seminar, on Medical and Surgical Diagnosis, Norton Infirmary, Louisville

JANUARY

5 Professor's Day, 8:30 a.m.-3:30 p.m. University of Kentucky Medical Center, Lexington

6 Neurology - Neurosurgery, Postgraduate Course, University of Kentucky Medical Center, Lexington

19 Methodist Evangelical Hospital, Postgraduate Education Day, Louisville

20 KAGP Northern Kentucky Seminar, 9:30 a.m., Holiday Inn Cincinnati South, South Fort Mitchell, Ky.

FEBRUARY

9-10 Pulmonary Physiology for Practicing Physicians. University of Kentucky Medical Center.

16 Obstetrics for General Practitioners. 9:00 a.m.—4:00 p.m., University of Kentucky Medical Center.

MARCH

24-26 Pediatrics Refresher Course, University of Kentucky Medical Center, Lexington.

30-31 Kentucky Heart Association, 12th Annual Symposium on Cardiovascular Disease, Brown Hotel, Louisville. Co-sponsored by KHA, University of Louisville School of Medicine and Jefferson County Academy of General Practice.

APRIL

13-14 KENTUCKY MEDICAL ASSOCIATION Interim Meeting, Cumberland Falls

21 Kentucky Thoracic Society Annual Meeting, in conjunction with Kentucky TB & RD Association Meeting, Rankin Amphitheater, Louisville General Hospital

IN SURROUNDING STATES

JANUARY

12-13 Ophthalmology, Postgraduate Course, Cleveland Clinic, Cleveland, O.

19 Vascular Surgery, Postgraduate Course, Cleveland Clinic, Cleveland, O.

22-27 American Academy of Orthopaedic Surgeons, Annual Meeting, Palmer House, Chicago

28-30 Southern Radiological Conference, Grand Hotel, Point Clear, Alabama

FEBRUARY

1-5 American College of Radiology, Drake Hotel, Chicago

2-6 American College of Cariology, Conrad Hilton Hotel, Chicago

9-11 American Academy of Occupational Medicine, Bellevue-Stratford Hotel, Philadelphia

21-23 American Academy of Allergy, Annual Meeting, Americana Hotel, New York City

28-Mar. 3 Southeastern Surgical Congress, Marriott Motor Hotel, Atlanta

MARCH

4-9 American Association of Pathologists and Bacteriologists, Statler-Hilton Hotel, Cleveland

7-10 New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans

21-Apr.2 "Laryngology and Bronchoesophagology" Postgraduate Course, Department of Otolaryngology of the Illinois Eye and Ear Infirmary and U. of I. College of Medicine, at the Infirmary

23-25 American Surgical Association, Boca Raton Hotel, Boca Raton, Fla.

APRIL

28-30 Third Annual Midwest Conference on Anesthesiology, Continental Plaza Hotel, Chicago.



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1965 CONSTITUTION AND BYLAWS
OF THE
KENTUCKY MEDICAL ASSOCIATION

Revised September 22, 1965

CONSTITUTION

Article I. Name of the Association
Article II. Purpose of the Association
Article III. Component Societies
Article IV. Composition and Meetings of the Association
Article V. Officers
Article VI. House of Delegates
Article VII. Districts, Sections and District Societies
Article VIII. Board of Trustees
Article IX. Funds and Expenses
Article X. Referendum
Article XI. The Seal
Article XII. Amendments
Article XIII. Definitions

Article I. Name of Association

The name and title of this organization shall be the Kentucky Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

Article V. Officers

Section 1. The officers of this Association shall be a President, a President-elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee from each District that may be established, and such other officers as may be provided for in the bylaws.

Section 2. The duties and terms of office of all officers of the Association shall be as prescribed in the bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the bylaws.

Section 2. Delegates shall be members of and elected by component societies in such manner as may be provided in the bylaws. Officers of the Association, Delegates and Alternate Delegates to the American Medical Association, and the five immediate Past Presidents shall be ex officio members of the House of Delegates and entitled to vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable. Provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select, including but not limited to an equal per capita assessment by class of membership, upon each component

county society. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

BYLAWS

Chapter I. Membership
Chapter II. Annual and Special Meetings of the Association
Chapter III. The House of Delegates
Chapter IV. Election of Officers
Chapter V. Duties of Officers
Chapter VI. Board of Trustees
Chapter VII. Discipline—The Judicial Council
Chapter VIII. Standing Committees and Councils
Chapter IX. Assessments and Expenditures
Chapter X. Rules of Conduct
Chapter XI. Rules of Order
Chapter XII. County Societies
Chapter XIII. Amendments

CHAPTER 1. MEMBERSHIP

Section 1. Membership in this Association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this Association unless he is a member, in good standing of a component society, nor may he maintain membership in a component county society unless he is a member, in good standing of this Association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship.

Section 2. Membership in the Association shall be divided into seven classes, to-wit: Active, Emeritus, Associate, Inactive, Student, Honorary and Special.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component county medical societies. To be eligible for active membership in any component county society, the applicant must be a doctor of medicine of good moral, ethical, and professional standing, who is licensed to practice medicine in Kentucky.

(b) Emeritus Members. Component societies may elect as a member-emeritus any doctor of medicine who is 70 years of age or who has retired from active practice and who has previously maintained active membership in good standing in his own society for twenty years or more. Emeritus members shall have the right to vote but shall not pay dues, hold office or be entitled to the benefits of Chapter VI, Section 9 of these Bylaws. They shall receive the Journal and other publications of the Association.

(c) Associate Members. The associate membership of the Association shall consist of the associate members of the various component county medical societies. To be eligible for associate membership in any component county society, the applicant must be ineligible for active membership and qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

(2) Interns, residents or teaching fellows who are doctors of medicine and who have complied with all pertinent regulations of the State Board of Health.

Associate members shall not have the right to vote nor to hold office, but shall receive the Journal and other publications of the Association.

(d) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive the Journal and other publications of the Association.

(e) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of

their choice. The membership year for student members shall run from September 1 to August 31 of each year.

(f) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(g) Special Members. Component societies may invite dentists, pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded the privilege of attending and participating in the scientific meetings of the society. Provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

Section 3. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

Section 4. Except as provided in Chapter VI, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association, shall be entitled to any of the rights or benefits of membership in this Association.

Section 5. Every new active member shall be required to attend and successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees. The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within two years after the member is first admitted to active membership shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component society, and shall not after one year be admitted to membership unless and until he has successfully completed the required orientation course.

CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

Section 1. The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

Section 2. The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or one of the vice presidents. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Section 3. The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

Section 4. Each member in attendance at any meeting shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

Section 2. The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of delegates representing fifty or more component societies. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

Section 3. When a special session is called, the Secretary shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

Section 4. The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

Section 5. In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active member of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

Section 6. Forty per cent of the qualified delegates, as defined by Article VI of the Constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

Section 7. Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary following its introduction. If the author be an individual member, it shall be signed by him. If the author be a group of members, it shall be signed by the authorized spokesman for that group. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 8. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Section 9. The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

Section 10. It shall consider and advise as to the material interests of the profession, and of the public

in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse information in relation thereto.

Section 11. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 12. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 13. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 14. It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

Section 15. The state shall be divided into the following districts:

No. 1.—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8—Boone, Campbell, and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10—Fayette, Jessamine, and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurel, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

Section 16. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 17. Except as provided in Chapter VI, Section 4, it shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 18. A digest of proceedings of the House of Delegates shall be published in the Journal of the Association.

CHAPTER IV. ELECTION OF OFFICERS

Section 1. The President-Elect and the Vice Presidents shall be elected for a term of one year. The Speaker of the House of Delegates, the Vice-Speaker of the House, the Secretary and the Treasurer shall be elected for terms of three years. The Trustees shall be elected for terms of three years and shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice President, Speaker or Vice Speaker of the House of Delegates, or Trustees, who has not been an active member of the Association for at least five years.

Section 2. During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as chairman at an organization meeting held during the Interim Meeting, or at some other appropriate place designated by the Board of Trustees at least four months before the Annual Meeting. The Committee, in addition to such other meetings as it may choose to hold, shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the Committee shall have a hearing. Before noon of the following day, the Committee shall post a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nominations for each office to be filled, and shall formally present said nominations to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussions or comment.

Section 3. The election of officers shall be held at the second meeting of the regular session of the House of Delegates.

Section 4. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect. Provided, however, that when there are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

Section 5. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of the Association shall be ineligible for any office for two years.

Section 6. The Delegates representing the counties in each District shall form the Nominating Committee for the purpose of nominating a Trustee for the District concerned. This committee shall hold a well publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting, for the purpose of discussing the nomination for the Trustee to serve the District. Additional nominations may be made from the floor when the Nominating Committee makes its report to the House of Delegates.

CHAPTER V. DUTIES OF OFFICERS

Section 1. Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parlia-

mentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President, in an amount not to exceed the total amount appropriated for that purpose in the annual budget.

Section 2. The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

Section 3. The Vice Presidents shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice President from the district from which the President was elected shall succeed to the office of the President.

Section 4. The President-Elect and the Vice Presidents, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties, in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses of the President.

Section 5. The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a non-voting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

Section 6. The Vice Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

Section 7. The Secretary shall advise the Executive Secretary in all secretarial matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and in the event of the death, resignation or removal of the Executive Secretary, shall assume the duties of that office until the vacancy is filled.

Section 8. The Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or the Executive Secretary and shall be countersigned by the Treasurer of the Association. Under unusual circumstances, when one or more of the above-named officials are not readily available, the President or the Chairman of the Board of Trustees is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Board of Trustees. The Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.

CHAPTER VI. BOARD OF TRUSTEES

Section 1. The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the three Vice Presidents, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary, the Treasurer, and the Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the President-Elect, the Secretary, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, to-wit, 14, and a majority of the full Executive Committee, to-wit, 4, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all of the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Section 2. The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

Section 3. Each Trustee shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the existing component societies and their members. He shall likewise hold at least one district meeting each year in order to afford a forum for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Treasurer upon a proper itemized statement, but this shall not be construed to include his expenses in attending the Annual Meeting of the Association.

Section 4. The Board shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press. Such communications shall be signed by the President of the Association and the Chairman of the Board.

Section 5. The Journal of the Kentucky Medical Association shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the Journal shall be elected by the Board. All money received by the Journal or by any member of its staff on its behalf, shall be paid to the Treasurer on the first of each

month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 6. All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

Section 7. In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the President may call a meeting of the delegates of record from the counties of that district for the purpose of submitting one or more nominees as candidates to fill the office until the Trustee's disability is removed or until the next meeting of the House of Delegates. The name or names of the nominee or nominees shall be submitted to the Board, which may elect an acting Trustee from them.

Section 8. The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

Section 9. The Board shall employ an Executive Secretary whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Secretary shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Treasurer. He shall within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a card index register of all practitioners in the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor of the Journal of the Kentucky Medical Association under supervision of the Board and in a similar capacity to the extent that other publications are authorized by the House of Delegates.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

CHAPTER VII. DISCIPLINE — THE JUDICIAL COUNCIL

Section 1. There is hereby created a Judicial Council composed of the Secretary of the Association and four members to be elected by the House of Delegates for terms of four years each. One member shall be elected from each of the traditional eastern, western, and central districts, and one member from the state at large. Members of the first Judicial Council shall be elected for terms of one, two, three, and four years, respectively so that thereafter, one member will be elected each year. The Council shall annually elect a chairman.

To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or as Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.

It shall be the duty of the Board of Trustees to nominate at least one candidate for each vacancy on the Judicial Council, but additional nominations may be made from the floor. Vacancies which occur between Regular Sessions of the House of Delegates, shall be filled by the Board of Trustees. No member, other than the Secretary, shall serve more than two consecutive terms.

Section 2. The Judicial Council shall be the Board of Censors of the Association. It shall be the final arbiter of all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Judicial Council without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the constitution, bylaws, or any rule or regulation of this Association, or the Principles of Ethics of the American Medical Association shall be liable to censure, fine, suspension, or expulsion upon order of the Judicial Council. Provided, however, that if in addition to discipline by the Association, the Judicial Council shall be of the opinion that the offending member's license to practice medicine should be revoked, it shall report this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Health for this purpose.

At the request of any member or aggrieved individual involved, the Judicial Council may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all such cases of initiation, intervention, or supersession, the due

process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

Section 3. It shall consider all appeals from the recommended decisions of individual trustees and District Grievance Committees. In the case of appeals from the decisions of individual trustees, the Judicial Council may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but all appeals from the recommended decisions of District Grievance Committees shall be considered on the record made before such committee. It shall be the duty of the Secretary to notify the parties with respect to its disposition of each case.

Section 4. The Judicial Council may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be considered on the record made before the component societies.

Section 5. Efforts toward conciliation and compromise shall precede the hearing of all disciplinary cases, but the decision of the Judicial Council shall be final.

Section 6. Component societies are encouraged to create suitable disciplinary procedures which guarantee due process, and to dispose of all disciplinary problems which come to their attention. It is recognized, however, that it may not be feasible for some societies to do so, and the District Grievance Committees hereinafter created, are designed to meet the needs of county societies which are without a functioning grievance committee.

Section 7. The trustee of each district is hereby designated the chairman of his District Grievance Committee. The Judicial Council shall designate two additional trustees from districts adjoining that of the chairman, and the three trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual trustees, shall be referred to the local grievance committee or the district grievance committee for the district in which the respondent physician or county society resides.

Section 8. District Grievance Committees shall investigate every grievance coming to their attention, taking care that the physician complained of shall have ample opportunity to respond to the complaint. If, after careful investigation, the complaint appears to be without merit, the committee shall so report to the Judicial Council, including sufficient facts in its report to enable the Judicial Council to form its own conclusions.

If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall be entitled to be represented by counsel, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided.

When all of the testimony has been heard and all evidence received, the committee shall make written findings and recomendations which it shall transmit to the Judicial Council, furnishing copies thereof to the parties.

Section 9. Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committee has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies, provided, however, that the Judicial Council may extend the time in which the transcript must be filed, upon request made within the initial thirty-day period.

CHAPTER VIII. STANDING COMMITTEES AND COUNCILS

Section 1. The Board of Trustees shall, upon nomination of its Executive Committee, appoint and designate the chairmen of four standing committees composed of not less than five nor more than seven members, as follows:

(a) A Committee to Study the Constitution and Bylaws.
(b) A Committee on Third-Party Medicine.
(c) A Committee on Arrangements for the Interim Meeting.
(d) An Advisory Committee to the Editor of the Journal.

Section 2. The Board of Trustees shall, in the same manner, (except as hereinafter provided) appoint and designate the chairmen of six Councils, composed of not less than five nor more than seven members, as follows:

(a) A Council on Scientific Assembly.
(b) A Council on Medical Education and Hospitals.
(c) A Council on Legislative Activities.
(d) A Council on Medical Services.
(e) A Council on Communications and Public Service.
(f) A Council on Allied Professions and Related Groups.

Section 3. The Executive Committee shall serve as the nominating committee for all Standing Committee and Council appointments, but the Trustees may make additional nominations from the floor. When the Executive Committee sits as such nominating committee, the President shall serve as Chairman.

Section 4. Except as otherwise provided herein, members of Standing Committees and Councils shall be appointed for terms of not less than one year and of not more than three years, and until their successors are appointed. Each committee and council (other than the Council on Scientific Assembly) shall meet and organize as soon after its appointment as possible, and shall meet again near the close of the associational year, for the purpose of formulating its annual report. It may meet at such other times as may be necessary or desirable. The Headquarters Office shall be the headquarters for all committees and councils, unless otherwise specifically ordered by the Board of Trustees or its Executive Committee, and all notices of committee meetings shall issue from the headquarters office at the direction of the chairman.

Five-member Committees and Councils shall have a quorum of three, and seven-member Committees and Councils shall have a quorum of four members present before any business other than the fixing of the time and place of the next meeting, may be transacted.

All committees, other than standing committees, shall be assigned to a council and shall report their activities and recommendations *only* to the council to which assigned. These reports will be reviewed by the various councils and no such reports or recommendations will be considered by the Board of Trustees unless and until reviewed by the proper council.

Each Standing Committee and Council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted, without alteration or amendment, to the House of Delegates

by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. Committees and Councils may submit supplemental reports if such reports are in the hands of the Secretary at least 48 hours in advance of the first meeting of the Regular Session of the House of Delegates.

Section 5. The President, Secretary, and Executive Secretary shall be ex officio members of all Committees and Councils, without power to vote except as otherwise specified herein.

Section 6. The Board of Trustees shall have power to establish such other committees as may, from time to time, appear to it to be advisable, and to prescribe their composition, the method of their appointment, and their duties. Such committees shall serve at the pleasure of the Board.

In addition, the Board of Trustees shall have power to appoint a representative from this Association to the Conference of Presidents and such other organizations as it shall determine.

Section 7. The Committee to Study the Constitution and Bylaws shall make a continuing study of the Constitution and Bylaws and shall annually recommend such revisions of either or both of these documents as changing times and conditions indicate.

Section 8. The Committee on Third Party Medicine shall make a continuing study of Third Party Medicine, and shall maintain liaison with all medical care plans which employ physicians on a salaried basis in this state. It shall mediate disputes between members and such plans, and shall continually strive to persuade such plans to shape their relations with their employed physicians and with the public, in conformity to the views of this Association.

Section 9. The Committee on Arrangements for the Interim Meeting shall have the responsibility of preparing the program for the Interim Meeting, and presenting it to the Board of Trustees or its Executive Committee for approval. Upon approval of the program thus presented, the Committee shall have the further responsibility of approving all arrangements for the Conference.

Section 10. The Advisory Committee to the Editor of the Journal shall provide support to the Editor and be available to him for consultation with respect to any matter concerning the Journal, on which he desires the Committee's advice and assistance. All papers of doubtful suitability for publication shall be referred by the Editor to the Advisory Committee, and its approval shall be required prior to the publication of any matter which is recognized to be of a controversial nature.

Section 11. The Council on Scientific Assembly shall consist of seven (7) members. The President, the President-Elect, and the chairmen of the Committees on Scientific and Technical Exhibits shall, by virtue of their respective offices, be voting members of the Council, with the President serving as Chairman and the President-Elect as Vice-Chairman. The remaining three members shall serve for terms of three (3) years each, with the term of one member expiring each year. The Council shall supervise and direct the planning, development and presentation of the scientific programs of the Annual Meeting each year. In addition, it shall be responsible for scientific and technical exhibits and all activities incident to the Annual Meeting, including golf and other forms of recreation and entertainment. These will include the duties heretofore imposed upon the Awards Committee to nominate the recipients of the Distinguished Service Medal, the Outstanding General Practitioner Award, and the R. Haynes Barr Award.

Thirty (30) days previous to each Annual Meeting, the Council shall prepare and issue a program announcing the order in which papers, discussions, and other business shall be presented, which program shall be adhered to as nearly as practicable. No county society, as such, shall serve as host society to the Annual Meeting.

Section 12. The Council on Medical Education and Hospitals shall direct and supervise the activities of the Association in the field of medical education, and shall maintain active liaison with the Kentucky Hospital Association. It shall seek to elevate the standards of postgraduate medical education in Kentucky, establishing and maintaining liaison with Kentucky's two medical schools and the Committee for the American Medical Association Education Research Foundation, and concerning itself with problems relating to medical and hospital care, general practice, and such other matters in this general field as may be referred to it by the Board.

Section 13. The Council on Legislative Activities shall direct and supervise the work of the Association as it pertains to state and national legislation, and shall formulate and submit a legislative program to the Board of Trustees for its consideration. The Council shall seek the enactment of the Association's legislative program into law, and shall resist the enactment of bills which the Board finds to be not in the best interests of the public or the profession. It shall maintain liaison with officials of state and national governments and shall work closely with the various county societies in carrying out the legislative program at both state and national levels.

Section 14. The Council on Medical Services shall supervise and direct the activities of the Association in the field of socio-economic development. It shall be charged with the promotion of voluntary health insurance programs in general and shall maintain active liaison with Kentucky Physicians Mutual, Inc., and Blue Cross plans. It shall advise on medical service contracts with the state and federal governments and shall serve as a clearing house on all fee schedules and other questions affecting the economics of medicine. It shall concern itself with the problem of providing adequate medical care for the aged, and shall maintain careful scrutiny of all state or national programs which purport to deal with this problem.

Section 15. The Council on Communications and Public Service shall supervise and direct all associational activity in the fields of public relations and service, including, but not limited to, rural health, schools, public health, emergency medical services and diabetes.

Section 16. The Council on Allied Professions and Related Groups shall concern itself with the development and promotion of improved health standards and shall establish and maintain liaison with the dental, nursing and pharmacy professions in this state. It shall supervise and direct the Association's activities in the fields of infant and maternal mortality, physical medicine and rehabilitation, industrial medicine, tuberculosis, blood banks and other related subjects, and shall interest itself in the work of voluntary health associations.

CHAPTER IX. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Members, $75, except Active Members who devote all of their time to teaching or research and have no private practice, $50.00; (2) Emeritus Members, no dues; (3) Associate Members, $8; (4) Inactive Members, $8; (5) Student Members, $1; (6) Honorary Members, no dues; (7) Special Members, no dues. Dues fixed by these Bylaws shall constitute assessments against the component societies. The Secretary of each component society shall forward its assessment together with its roster of all officers and members, list of delegates and list of non-affiliated physicians

of the county to the Secretary of this Association as of the first day of January in each year.

Section 2. Any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective.

CHAPTER X. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

CHAPTER XI. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

CHAPTER XII. COUNTY SOCIETIES

Section 1. Except as provided in Section 4 of this Chapter, all county medical societies in this state which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary. The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 4. Only one component society shall be chartered in any county. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky Medical Association.

Section 5. In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Section 6. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky Medical Association, and shall be classified in accordance with Chapter I, Section 2 of these Bylaws. Provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 7 and/or 9 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

Section 7. Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides.

Section 8. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 9. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

Section 10. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days appeal to the Judicial Council, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Judicial Council to those portions of the transcript upon which he relies.

Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership. Provided, however, that an appeal shall stay the suspension until a final decision is made by the Judicial Council.

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees.

Section 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such

labors. Official positions and other references shall be unstintingly given to such members.

Section 12. At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session. Provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 members in good standing, plus one delegate for one or more members in excess of multiples of 25. Provided, however that each component society shall be entitled to at least one delegate regardless of the number of members it may have and the secretary of the society shall send a list of such delegates to the Secretary of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its delegates each year.

Section 13. The secretary of each component society shall keep a roster of its members and a list of non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary of the Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 14. The secretary of each component society shall report to the Journal of the Kentucky Medical Association full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

CHAPTER XIII. AMENDMENTS

These Bylaws may be amended at any session of the House of Delegates by a two-thirds vote of all the delegates present at that session, after the amendment has laid on the table for one day.

Rheumatic Fever

(Continued from Page 951)

8. Ash, Rachel, Am. J. Dis. Child, 63:1, 1962.
9. Paul. J. R., Medicine, 7:383, 1928.
10. Jones, T. D., J.A.M.A., 126:481, 1944.
11. Cooperative Report United Kingdom and United States, Circulation 11:343, 1955.
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13. Rheumatic Fever in Children and Adolescents, Ann. of Internal Med., 60#2, Part II, February 1964.
14. Hartman, S. A. and Bland, E. F., Am. J. Med., 10:47, 1951.
15. Brown, M. G. and Wolff, L., N.E.J.M., 223:242, 1940.

Myocardial Infarction

(Continued from Page 962)

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8. Robb, G. P., and Marks, H. H.: *What Happens to Men Disabled by Heart Disease.* Trans. Assn. Life Ins. Med. Directors America. 37:171-200, 1953.
9. Weiss, M. M., Sr.: *Ten-year Prognosis of Acute Myocardial Infarction.* Am. Jour. Med. Sci. 231:9-12 (Jan.) 1956.
10. Weiss, M. M., Sr. and Weiss, M. M., Jr.: *A Five-year Prognostic Study of Acute Myocardial Infarction:* J. of American Geriatrics Society 5:591-594, (June) 1957.
11. Weiss, M. M., Sr. and Weiss, M. M., Jr.: *Five-Year Follow-up Study of Men Who Returned to Work after a Myocardial Infarction,* J.A.M.A., 168:17-19, (Sept. 6) 1958.

Radiologists Choose Officers

Thomas R. Marshall, M.D., Louisville, was installed as president and Robert D. Shepard, M.D., Lexington, was named president-elect of the Kentucky Chapter of Radiology at the Chapter meeting September 23 during the KMA Annual Meeting in Louisville. Robert H. Greenlaw, M.D., Lexington, is secretary-treasurer.

Urologists Elect Dr. Martin

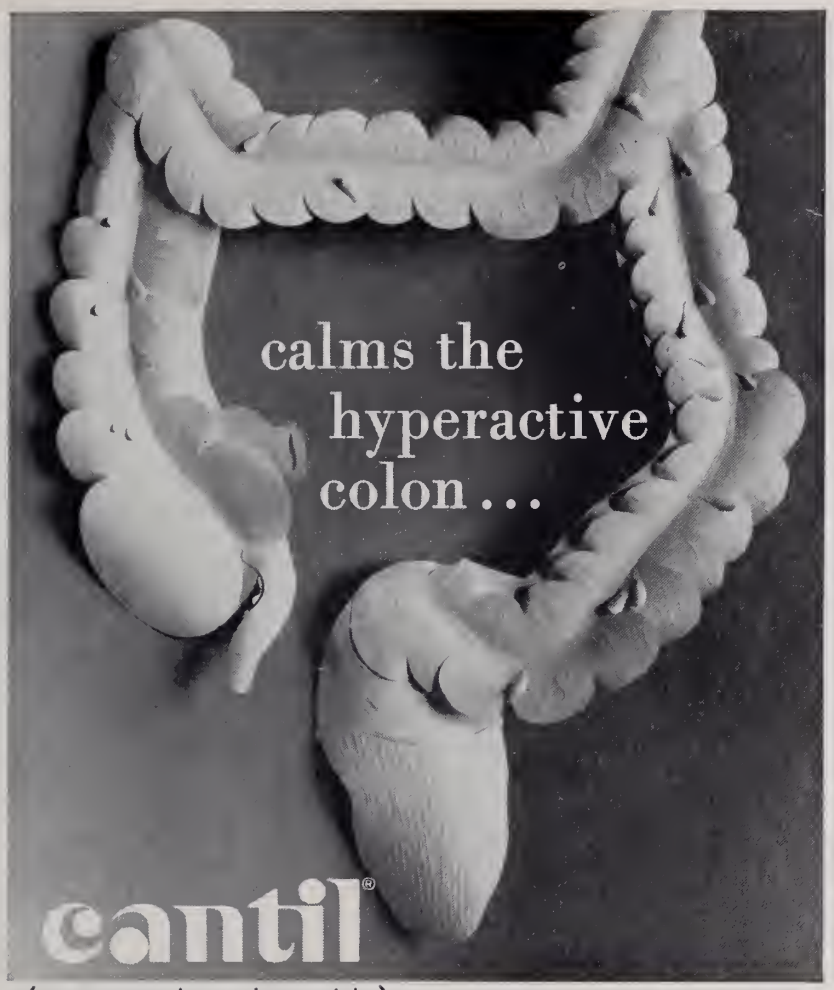
Herman E. Martin, M.D., Ashland, was elected president of the Kentucky Urological Association for the 1965-66 associational year, it was announced recently. Doctor Martin, elected at the September 21 meeting of the Association, succeeds Henry I. Berman, M.D., Louisville, in office. F. F. Ferguson, M.D., Madisonville, was re-elected secretary-treasurer.

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1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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KENTUCKY MEDICAL ASSOCIATION

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Under the Supervision of the Board of Trustees

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*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

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Pleasant tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be administered by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. Contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

PEDIATRIC PIPTAL® WITH PHENOBARBITAL

each cc. contains: 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol in a pleasant-tasting solution.

LAKESIDE LABORATORIES, INC.
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duodenal ulcer

Prompt relief of pain and spasm in functional g.i. distress...



gastric ulcer

PIPTAL® (pipenzolate bromide) efficiently suppresses acid secretion and motility . . . relieves pain and spasm of peptic ulcer. Despite its potent gastrointestinal effects, "its clinically effective therapeutic dose is well below that required to produce side reactions."[1] Because urinary retention is rarely a problem, PIPTAL (pipenzolate bromide) is "a highly desirable drug in the treatment of peptic ulcer in older patients . . ."[2] Tolerance to PIPTAL (pipenzolate bromide) has not been demonstrated, and the drug may be administered over prolonged periods without loss of efficacy. *PIPTAL-PHB is specifically designed for the tense ulcer patient who will benefit from the sedative effect of phenobarbital.*

1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957

2—Asher, L.M.: Am. J. Digestive Diseases *4*:272 (Apr.) 1959

PIPTAL®
(pipenzolate bromide)

PIPTAL®-PHB
(phenobarbital, 16 mg., pipenzolate bromide, 5 mg.)

IN BRIEF: PIPTAL—Each tablet contains 5 mg. pipenzolate bromide, PIPTAL-PHB—Each tablet (or 5 cc. of elixir) contains phenobarbital (warning: may be habit forming) 16.0 mg., Piptal (pipenzolate bromide) 5 mg. The elixir contains alcohol 20%.

Side Effects: Dry mouth, blurring of vision or drowsiness may occur.

Contraindications: Withhold in glaucoma, bladder or g.i. obstruction, cardiac arrhythmias and in sensitivity to anticholinergics or phenobarbital (Piptal-PHB). Caution should be observed in patients with prostatic hypertrophy.

Administration and Dosage: PIPTAL or PIPTAL-PHB Tablets: One tablet three times a day before meals and one or two tablets at bedtime. (PIPTAL-PHB Elixir: One teaspoonful three or four times daily for adults and children over six years of age.)

Supplied: PIPTAL (pipenzolate bromide) 5.0 mg. Tablets—bottles of 100. PIPTAL-PHB Tablets—bottles of 100. PIPTAL-PHB Elixir—bottles of 8 fluid ounces.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

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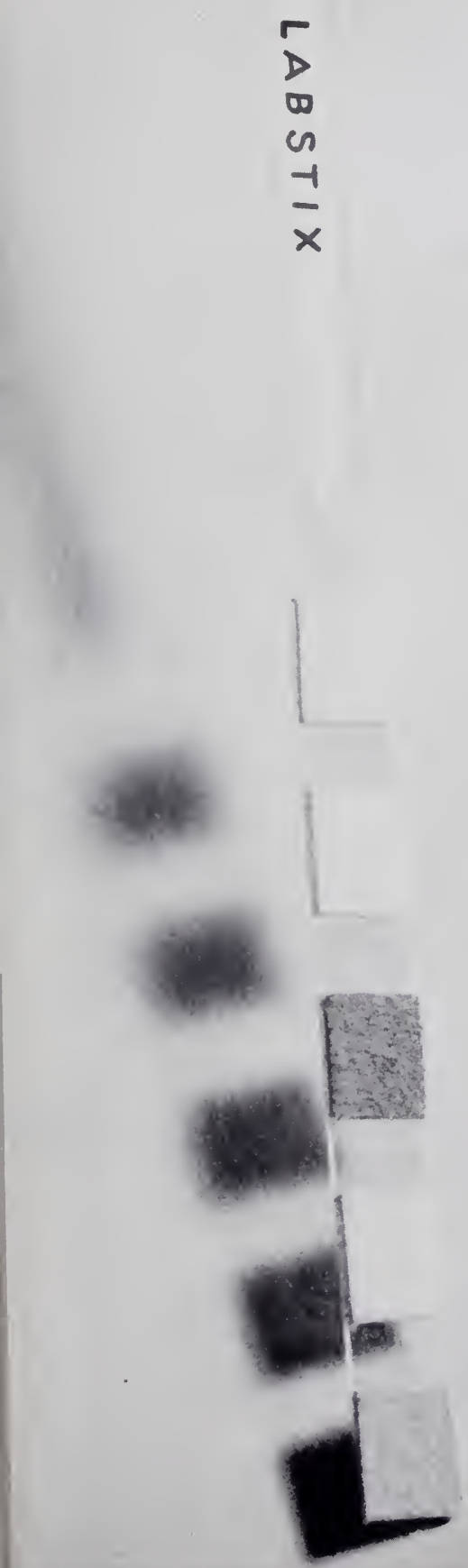
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The Somatic Mask: chest pain—heart disease or psychic tension?

Precordial pain as well as tachycardia, palpitation, breathlessness and faintness or arrhythmias are classic signs of cardiac disease. In many cases, however, they may represent a "somatic mask"—a psychophysiological equivalent of psychic tension.

Valium (diazepam) reduces the patient's disturbing psychic tension and helps improve such related symptoms as sadness and feelings of hopelessness, fatigue, insomnia, crying spells and nervousness.

In prescribing: Dosage—Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hrs, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed.

Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Supplied: Tablets, 2 mg and 5 mg; bottles of 50 and 500.

Valium® (diazepam)

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